

# ALLISON BALL AUDITOR OF PUBLIC ACCOUNTS

November 25, 2025

Nathan Goens Assistant General Counsel Justice and Public Safety Cabinet 125 Holmes Street Frankfort, Kentucky 40601

Sent via email to Justice.RegsContact@ky.gov

Re: Auditor of Public Accounts' Comment Letter Regarding Proposed Regulations 505 KAR 1:140E and 1:410E

Dear Mr. Goens,

On September 25, 2025, Governor Andrew Beshear "provided an update on his administration's aggressive plan to implement system-wide improvements in Kentucky's juvenile justice system." That announcement contained the usual political platitudes about his administration's hollow work that has failed to solve the multitude of problems within Kentucky's Department of Juvenile Justice (DJJ)—problems that are harming children and DJJ staff.

Nested within that empty rhetoric was a notice to the public of the filing of two administrative regulations—505 KAR 1:140E and 1:410E—purporting to address the wrongful use of isolation within DJJ facilities. Governor Beshear branded these regulations as "updates . . . to prioritize the safety and mental health of juveniles." The only information provided about these regulations was that they allegedly "mandate DJJ leadership reviews, approves [sic] time limits and requires [sic] all DJJ staff who interact with youth to be trained on the new regulation."

But the devil is in the details. These regulations do nothing to improve the administration's damaging use of isolation against Kentucky's children housed within DJJ's walls. Just as bad, the regulations do nothing to address the plethora of other problems within DJJ revealed by public reporting, a Biden administration investigation,<sup>2</sup> and the APA's 231-page report about its examination of DJJ. Kentucky Auditor of Public Accounts (APA) Allison Ball is submitting this comment letter to explain all of this to the public and the administration with the hope that this explanation sparks real change within DJJ.

<sup>&</sup>lt;sup>1</sup> Gov. Beshear: Kentucky Department of Juvenile Justice Enhances Safety, Boosts Successful Outcomes, Justice and Public Safety Cabinet (Sept. 25, 2025), https://justice.ky.gov/News/Pages/djj-emergency-regulations.aspx.

<sup>&</sup>lt;sup>2</sup> Justice Department Announces Civil Rights Investigation into Conditions at Kentucky Youth Detention Centers, United States Department of Justice (May 15, 2024), https://www.justice.gov/archives/opa/pr/justice-department-announces-civil-rights-investigation-conditions-kentucky-youth-detention.

#### **BACKGROUND**

### DJJ needs fixing.

As early as the fall of 2021, public reporting revealed chaos within DJJ.<sup>3</sup> Allegations of abuse cover-ups,<sup>4</sup> the failure to properly train employees,<sup>5</sup> and riots<sup>6</sup> prompted calls for a formal investigation into the Beshear administration's management of DJJ.<sup>7</sup>

All of this, and more, prompted the General Assembly to unanimously enact 2023 Ky. Acts Ch. 106 (2023 Senate Bill 162). This bill sought to improve DJJ's operations for the benefit of all children housed and staff operating within its walls. Part of achieving that improvement necessitated understanding the problems giving rise to the turmoil within DJJ. So in that legislation, the General Assembly directed the APA to conduct a "full performance review" of DJJ's eight juvenile detention centers.

The APA dug deep into the root causes of DJJ's noted deficiencies and released a 231-page report on January 31, 2024. Of note, the examination found that, of course, it all starts at the top: DJJ "lacks a unified strategic direction" from top leadership within the Beshear administration, which is leaving facilities on islands to fend for themselves. Except for the instances of simply a bad apple within the bunch, this lack of leadership is the main catalyst for DJJ's problems that are, again, harming Kentucky's DJJ youth and staff.

The APA's report provided numerous recommendations for fixing DJJ. But Beshear administration officials have seemingly ignored them, as the inhumane conditions within DJJ's facilities continue. More recently, a 350-pound correctional captain broke the left arms of two teenage boys in separate incidents who were being restrained. Guards used pepper spray on the genitals of an autistic, suicidal teenage boy, mocking his pain and suffering. Guards laughed as

209 St. CLAIR STREET FRANKFORT, KY 40601-1817

TELEPHONE 502.564.5841
FACSIMILE 502.564.2912

<sup>&</sup>lt;sup>3</sup> See, e.g., John Cheves, 'So many flaws.' Broken bones, abuse, and isolation inside Kentucky juvenile lockups, Lexington Herald-Leader (Oct. 21, 2021), https://www.kentucky.com/news/politics-government/article252923268.html; John Cheves, 'Struggling to feel safe.' Reports reveal chaos inside KY juvenile justice facilities, Lexington Herald-Leader (Dec. 13, 2022), https://www.kentucky.com/news/politics-government/article269782582.html.

<sup>&</sup>lt;sup>4</sup> John Cheves, 'Set up for failure.' KY youth worker claims pressure to water down incident report, Lexington Herald-Leader (Sept. 23, 2021), https://www.kentucky.com/news/politics-government/article253944928.html.

<sup>&</sup>lt;sup>5</sup> John Cheves, *Kentucky cuts academy training, sends new juvenile justice employees straight to work*, Lexington Herald-Leader (Nov. 15, 2021), https://www.kentucky.com/news/politics-government/article255771956.html.

<sup>&</sup>lt;sup>6</sup> John Cheves, *Incident at KY juvenile justice center in Bowling Green causes 'significant' damage*, Lexington Herald-Leader (Aug. 26, 2022), https://www.kentucky.com/news/local/crime/article264957909.html.

<sup>&</sup>lt;sup>7</sup> John Cheves, *Lawmakers call for investigation, new leadership at KY juvenile justice agency*, Lexington Herald-Leader (Feb. 2, 2023), https://www.kentucky.com/news/politics-government/article272019047.html.

<sup>8</sup> Commonwealth of Kentucky Department of Juvenile Justice, APA (Jan. 29, 2024), https://www.auditor.ky.gov/Auditreports/Miscellaneous/KentuckyDJJPerformanceReview.pdf (APA Report).
9 APA Report at 2, 99–101.

<sup>&</sup>lt;sup>10</sup> John Cheves, '350 pounds of terror.' How a KY juvenile justice guard broke the arms of two boys, Lexington Herald-Leader (July 24, 2025), https://www.kentucky.com/news/politics-government/article298905720.html.

<sup>&</sup>lt;sup>11</sup> John Cheves, *Reports: KY juvenile justice guards taunt youths, pepper spray genitals and laugh at pain*, Lexington Herald-Leader (July 24, 2025), https://www.kentucky.com/news/politics-government/article299233484.html.

they pranked a mentally ill boy in isolation by continuously flushing a toilet.<sup>12</sup> An asthmatic boy was pepper sprayed twice in the face and then left in his cell without care.<sup>13</sup> And youth have been served spoiled milk, denied running water, deprived of essential prescription medications, and forced to sit in vomit-covered cells.<sup>14</sup>

Kentucky's youth continue to endure mistreatment, and DJJ staff are being set up to fail. And it's not just about DJJ youth and staff. We cannot expect these children to reenter society as productive citizens if DJJ remains this dysfunctional. So for the sake of all Kentuckians, DJJ needs to be fixed.

### DJJ's use of isolation, in particular, needs fixing.

Public reporting flagged DJJ's use of isolation as an issue that needed investigation.<sup>15</sup> The APA dug deeper into that issue, <sup>16</sup> which continues to this day.<sup>17</sup>

The term "isolation" has many different names and variations as to how, when, and where it is applied. But at bottom, when a detained youth is physically or socially isolated for disciplinary or administrative purposes, that youth is said to be put in "isolation" from activities, peers, and staff.

As identified in the APA's report, no substantive research exists showing the benefits of placing youth in isolation. Yet an abundance of data and research indicates that isolation causes a great deal of harm to youth, particularly those with disabilities or histories of trauma and abuse. This is why national organizations caution against the use of isolation and often recommend its prohibition.<sup>18</sup>

Especially when used improperly, isolation can increase a youth's risk for mental health issues, self-harm, and recidivism. So, as outlined in the APA's report, isolation should be used only in very specific and narrowly defined circumstances, confined to the following situations:

• Immediate Safety Threat. When a child poses an imminent threat to themselves or others, including staff, and all other attempts to de-escalate the situation have failed, isolation may

<sup>17</sup> See, e.g., John Cheves, KY juvenile justice staff skip safety checks on youths, falsify observation logs, Lexington Herald-Leader (Oct. 20, 2025), https://www.kentucky.com/news/politics-government/article312495449.html.

209 ST. CLAIR STREET FRANKFORT, KY 40601-1817

TELEPHONE 502.564.5841
FACSIMILE 502.564.2912

AN EQUAL OPPORTUNITY EMPLOYER MIFID

<sup>&</sup>lt;sup>12</sup> John Cheves, *KY juvenile justice guards laughed as they pranked mentally ill boy with a flushing toilet*, Lexington Herald-Leader (July 24, 2025), https://www.kentucky.com/news/politics-government/article292728524.html.

<sup>&</sup>lt;sup>13</sup> John Cheves, *Asthmatic boy was pepper sprayed then left in cell at KY juvenile justice center*, Lexington Herald-Leader (July 24, 2025), https://www.kentucky.com/news/politics-government/article292351724.html.

John Cheves, 'Dysfunction': Teens' grievances reveal safety, hygiene problems in KY juvenile justice facilities,
 Lexington Herald-Leader (May 9, 2024), https://www.kentucky.com/news/politics-government/article288277830.html.
 Natalia Martinez, Children kept in isolation for weeks, attorney testifies to lawmakers about youth detention

Natalia Martinez, Children kept in isolation for weeks, attorney testifies to lawmakers about youth detention facilities, WAVE (Oct. 12, 2023), https://www.wave3.com/2023/10/13/children-kept-isolation-weeks-attorney-testifies-lawmakers-about-youth-detention-facilities/.

<sup>&</sup>lt;sup>16</sup> APA Report at 1, 20–32.

<sup>&</sup>lt;sup>18</sup> See, e.g., Council of Juvenile Correctional Administrators Toolkit: Reducing the Use of Isolation, Council of Juvenile Justice Administrators (Mar. 2015), https://cjja.net/wp-content/uploads/2022/04/CJCA-Toolkit-Reducing-the-Use-of-Isolation-1.pdf (CJJA Toolkit); Annie E. Casey Foundation, Juvenile Detention Facility Assessment, Juvenile Detention Alternatives Initiative, 90–105 (2014 update), https://stopsolitaryforkids.org/wp-content/uploads/2016/06/JDAI-Detention-Facility-Assessment-Standards.pdf (JDAI Standards).

be used as a temporary measure to ensure safety. But continuous monitoring and support of the child must occur.

- Suicide Risk. If a child is actively suicidal, and isolation is deemed the only way to prevent immediate self-harm, it may be considered. But the child must be provided with extensive and immediate mental health intervention, both during and after the isolation period.
- **Medical Isolation**. In some cases, such as during an infectious disease outbreak or pandemic, isolation may be necessary to prevent the spread of illness. But efforts should be made to maintain social contact and provide emotional support to the isolated juvenile.

Even in these extreme cases when isolation is used, officials must maintain proper oversight of its use and adhere to the following:

- The duration of isolation should be as short as possible, with constant monitoring and reevaluation of the situation.
- The conditions of isolation must be humane and respectful. Adequate lighting, ventilation, access to hygiene facilities, and age-appropriate reading materials should be provided.
- Regular contact with staff and mental health professionals is essential. The isolated juvenile should not be left alone for extended periods.
- Alternative solutions should always be explored first. De-escalation techniques, conflict resolution methods, and access to calming activities should be prioritized before resorting to isolation.
- All staff should be properly trained in the procedures for placing a child in isolation and the services and privileges that should still be afforded to them.
- Data from written documents and digital programs should be collected and reviewed routinely to monitor the use and overuse of isolation.

Despite the existence of longstanding available guidance like that above, proffered by the Council of Juvenile Justice Administrators (CJJA) and the Juvenile Detention Alternatives Initiative (JDAI), the APA found that DJJ used isolation in contravention of that guidance, as well as many other use-of-isolation issues:

• JDAI Standards prohibit the use of isolation "as a means of ensuring [a child's] safety" from other children. 19 But this was a practice used by at least one DJJ detention facility. 20

<sup>&</sup>lt;sup>19</sup> JDAI Standards at 20.

<sup>&</sup>lt;sup>20</sup> APA Report at 22.

- JDAI Standards require that isolation only be used "as a temporary response to behavior that threatens immediate harm to the youth or others." But the APA found that DJJ used isolation as a preventative measure and in response to historical behaviors, not immediate threats of harm from the youth to others.<sup>22</sup>
- DJJ had varying definitions and descriptions of the use of isolation as between juvenile detention centers and youth development centers, creating confusion and the improper application of isolation practices by DJJ staff.<sup>23</sup>
- Prohibited by JDAI standards<sup>24</sup> and DJJ's own policies and procedures, isolation was improperly used for disciplinary, non-behavioral, housing assignment, and staffing shortage purposes.<sup>25</sup>
- Isolation was deficiently implemented:
  - o Isolation was imposed 1,579 times in 2023 across DJJ's eight juvenile detention facilities, which translates to an average of 197 occurrences per month.<sup>26</sup> This figure, in and of itself, raises serious concerns about DJJ's overuse of isolation.
  - O JDAI Standards require that a youth is "return[ed]... to programming as soon as the youth has regained self-control and is no longer engaging in behavior that threatens immediate harm to the youth or others."<sup>27</sup> One child was confined to isolation for two days, even after he presented as calm, had no current or documented behavior or disciplinary issues, and was observed sleeping or standing at his door for most of the time.<sup>28</sup>
  - O JDAI Standards prohibit the use of isolation "for discipline, punishment, administrative convenience, retaliation, staffing shortages, or reasons other than a temporary response to behavior that threatens immediate harm to a youth or others." Yet one child was isolated from every other child and activity for three days based on a previous altercation with two other children placed at the child's same facility. This also contravenes JDAI standards for failing to return a calm child to the general population, an observation made in numerous other instances as well. 32

<sup>&</sup>lt;sup>21</sup> JDAI Standards at 97.

<sup>&</sup>lt;sup>22</sup> APA Report at 22.

<sup>&</sup>lt;sup>23</sup> APA Report at 22–24.

<sup>&</sup>lt;sup>24</sup> JDAI Standards at 97.

<sup>&</sup>lt;sup>25</sup> APA Report at 24–32.

<sup>&</sup>lt;sup>26</sup> APA Report at 29.

<sup>&</sup>lt;sup>27</sup> JDAI Standards at 97.

<sup>&</sup>lt;sup>28</sup> APA Report at 26.

<sup>&</sup>lt;sup>29</sup> JDAI Standards at 97.

<sup>&</sup>lt;sup>30</sup> APA Report at 27–28.

<sup>31</sup> JDAI Standards at 97.

<sup>&</sup>lt;sup>32</sup> APA Report at 29.

- O Some facilities use video, instead of in-person, observation of children in isolation.<sup>33</sup> A lack of any human contact during isolation can traumatize a child and cause serious mental health issues.
- Documentation kept about observations of the children in isolation was unreliable and incomplete and raised questions about facilities' adherence to many use-ofisolation rules, including the required 15-minute check-ins with these isolated children.<sup>34</sup>

The APA offered over a dozen recommendations to help solve the problems identified by public reporting and the APA's examination.<sup>35</sup> There is no indication DJJ has implemented any of them.

### The proposed regulations fail our kids, DJJ staff, and Kentuckians in general.

As discussed below, proposed regulations 505 KAR 1:140E and 1:410E do nothing more than rebrand DJJ's already existing policies on the use of isolation and DJJ's deficiencies in the execution of those policies. If these regulations are not meaningfully changed, with a clear and articulate plan for their execution, DJJ youth and staff—and in turn, the general public—will continue to be harmed.

#### DISCUSSION

If the problems within DJJ are to be fixed, honest conversations—and not image-preserving political press conferences and releases—need to be had. The APA's involvement in this conversation began with the release of its 231-page report identifying issues within DJJ and providing solutions for the benefit of the children and staff within DJJ. It appears the Beshear administration ignored that report, reflected by the two regulations' deficiencies discussed below.

First, 505 KAR 1:410E is simply a rebrand of DJJ's previous isolation policy. It does nothing to actually solve the issue of DJJ's use of isolation on children. Second, 505 KAR 1:140E repeals an entire DJJ policy that included rules for more than just the use of isolation; yet DJJ failed to replace those now-repealed rules with any new rules. Third, neither regulation does anything to address any of the findings and recommendations provided in the APA's report about its examination of DJJ. These deficiencies need to be fixed.

#### I. 505 KAR 1:410E is smoke and mirrors.

505 KAR 1:410E is disappointing. Rather than do what it has been branded as doing, this regulation fails to bring about needed change. It seems to be a public-relations stunt to make it look like the Beshear administration is doing something about DJJ's abhorrent use of isolation against DJJ youth. And the worst part about that is harm will continue to befall upon DJJ youth, DJJ staff, and Kentuckians in general.

<sup>&</sup>lt;sup>33</sup> APA Report at 28.

<sup>&</sup>lt;sup>34</sup> APA Report at 28–29.

<sup>&</sup>lt;sup>35</sup> APA Report at 30–32.

# A. The proposed regulation simply changes the word "isolation" to the phrase "restrictive housing."

Section 1 of 505 KAR 1:410E, in particular, reveals an amendment was made to simply stop the use of the term "isolation" and replace it with the use of the phrase "restrictive housing" instead. The Beshear administration's desire to rebrand DJJ's isolation practices and call it something else is a ploy to hide the fact that DJJ is continuing its problematic use of isolation.

This kind of political doublespeak will not solve that problem. In fact, it may spark greater use of isolation by desensitizing DJJ officials to its use, as "restrictive housing" sounds a lot better than "isolation." But, to prevent all of that, the proposed regulation should be amended to call a spade a spade and continue the use of the term "isolation."

### B. The proposed regulation does not define "restrictive housing."

While 505 KAR 1:410E outlines some procedures for the use of isolation, it does not actually define the phrase "restrictive housing." In other words, it is unclear what kind of conditions must exist for a child to be fairly characterized as having been placed in "restrictive housing." Without such a definition, broad discretion is left to DJJ facilities to determine when exactly a child is considered to be in isolation, and thus when the strictures on the use of isolation apply. And as we've seen, broad discretion given to DJJ has led to the chaos identified by public reporting and the APA's examination.

If the phrase "restrictive housing" is to be used, it should be defined to encompass any physical or social isolation for disciplinary or administrative purposes. This broad definition would leave no doubt as to when isolation is used and would ensure that DJJ staff cannot escape the strictures of the policies and procedures governing its use.

#### C. Too much discretion is given to DJJ as to when to use isolation.

Section 1(2) of 505 KAR 1:410E outlines a series of triggers for the use of isolation. Of most concern is Subsection (i), which broadly allows the use of isolation in any instance in which DJJ staff feel as though a child is demonstrating "[a]ny other serious or violent behavior that compromises the safety and security of residents or staff." The fear is that DJJ will broadly use this catchall provision to justify inappropriate uses of isolation, especially uses that do not conform to best practices.

The proposed regulation must be amended to prevent that from happening. Greater strictures need to be placed to ensure that DJJ cannot justify its improper use of isolation with reliance on that catchall provision.

#### D. Section 1(3) violates best practices.

Section 1(3) appears to allow DJJ staff to refrain from conducting routine checks of youth in isolation and to leave a child in isolation overnight. Both violate best practices.

JDAI Standards require room checks on youth "at intervals not to exceed 15 minutes, *including at times when youth are asleep*." JDAI Standards also prohibit the use of isolation for more than "four hours." Section 1(3), however, "suspend[s]" the "time periods in which action is necessitated by" the proposed regulation "during resident sleeping hours from 8:00 p.m. to 6:00 a.m., and any delayed assessment shall occur within two (2) hours of 6:00 a.m." In other words, this appears to mean that any action required by the proposed regulation while the child is in isolation doesn't have to occur between the hours of 8:00 p.m. and 6:00 a.m. What that seemingly means is that routine and mental health check-ins between those hours are not required and that a child can be left in isolation between those hours. Again, both violate best practices.

If that is not the intended result of Section 1(3), then that wording must be clarified. If that is the intended result of Section 1(3), then that language must be amended to comply with best practices.

# E. Section 1(4) doesn't make any sense and allows for the use of isolation in contravention of best practices.

Section 1(4) requires DJJ staff to explain to a child the reason for his or her isolation, give an opportunity for the child to explain him or herself, and have the child review and sign a behavioral release plan created to set the requirements for the child's release from isolation. The kicker is that this must all occur *before* the child goes into isolation. This whole scenario makes no sense and will lead to the improper use of isolation.

If a child is calm enough to have an extensive and detailed conversation about the incident giving rise to what DJJ staff believe necessitates isolation, to review a behavioral management plan created for him or her, and to sign off on it, all *before* going into isolation, then the child should not be placed in isolation at that point at all. JDAI Standards require that a child be "return[ed] . . . to programming as soon as the youth has regained self-control and is no longer engaging in behavior that threatens immediate harm to the youth or others." It would seem impossible for everything outlined above to successfully occur unless the child is calm and has regained self-control. And if that's the case, the child should not be placed in isolation.

True, it appears that Section 1(4) is meant to capture the portion of the JDAI Standards that require an explanation to the child about the reason for isolation and his or her release upon self-control.<sup>39</sup> But what is not a part of those standards is the requirement that the child review and sign a comprehensive behavioral management plan before being placed in isolation. And the reason for that is that if a child is able to successfully do that, this time-consuming act would show that the child no longer needs isolation.

The JDAI Standards outline a congruent way of giving notice to a child about the reason for his or her isolation and what he or she needs to do to rejoin the general population. But Section 1(4) does not and needs to be fixed in accordance with those standards.

<sup>&</sup>lt;sup>36</sup> JDAI Standards at 108 (emphasis added).

<sup>&</sup>lt;sup>37</sup> JDAI Standards at 98.

<sup>&</sup>lt;sup>38</sup> JDAI Standards at 97.

<sup>&</sup>lt;sup>39</sup> JDAI Standards at 97.

### F. The proposed regulation is concerning because it appears to condition a child's release from isolation on more than it should.

As noted numerous times, JDAI Standards require a return of the child to the general population "as soon as the youth has regained self-control and is no longer engaging in behavior that threatens immediate harm to the youth or others." Section 1(6), however, conditions release on the child being "under reasonable control *and demonstrating behavior according to the terms of the plan for release.*" In other words, even if the child is demonstrating self-control and is no longer engaging in behavior that threatens immediate harm to others, the child must still satisfy whatever conditions exist in that child's behavioral release plan before release.

Section 1(6) should be amended to conform to the CJJA Toolkit and JDAI Standards. Conditioning a child's release from isolation on more than what is provided by these standards risks further trauma and mental health harm to the isolated child. That risk is amplified by the fact that DJJ staff can seemingly impose whatever subjective conditions they want in a behavioral release plan that will prevent a child from release back into the general population.

#### G. Section 2 violates best practices.

Section 2 sets out a continuum for approval of lengthening the time of isolation to longer than four hours and lays out what must be done during that time. It also conditions the release of the child back into the general population on compliance with the child's behavioral improvement plan. Both rules violate best practices.

JDAI Standards prohibit the use of isolation for more than four hours in any situation whatsoever. The only options that exist after four hours are: (1) a return to the general population; (2) special individualized programming that does not include isolation; or (3) transportation to a mental health facility. In sum, in no circumstance should a child be placed in isolation for more than four hours. Yet Section 2 of the proposed regulation allows a child to be placed in isolation *for up to three days*. The proposed regulation should be amended to reflect JDAI Standards and the CJJA Toolkit.

Additionally, as discussed numerous times, conditioning a child's release on more than a child regaining control and no longer engaging in behavior that threatens others is in contravention of best practices.<sup>44</sup> Yet, as before, Section 2 conditions release of the child on the child's compliance with that child's behavioral improvement plan. The proposed regulation should be amended to reflect JDAI Standards and the CJJA Toolkit on this point, as well.

<sup>&</sup>lt;sup>40</sup> JDAI Standards at 97.

<sup>&</sup>lt;sup>41</sup> See also 505 KAR 1:410E Section 4(4).

<sup>&</sup>lt;sup>42</sup> JDAI Standards at 98.

<sup>&</sup>lt;sup>43</sup> JDAI Standards at 98.

<sup>&</sup>lt;sup>44</sup> JDAI Standards at 97.

# H. More broadly, the proposed regulation doesn't change anything and appears to be an image-preserving measure.

One of the most disappointing parts of 505 KAR 1:410E is it fails to effectuate any meaningful change to DJJ's use of isolation. Indeed, the proposed regulation looks more like a public-relations exercise than a real attempt to effectuate meaningful change.<sup>45</sup>

This can be seen by comparing 505 KAR 1:410E with the regulation it is replacing and DJJ Policy 717—that is, DJJ's policy (now getting repealed by proposed regulation 505 KAR 1:140E) governing the use of isolation across all eight DJJ juvenile detention facilities. The following chart points out seven policies touted as updates that, in reality, already existed in the now-replaced regulation and the now-repealed DJJ Policy 717.

Policy	Location in 505 KAR 1:410E	Location in DJJ Policy 717 or Previous Regulation
Checks of the isolated youth	Section 1(5)	Policy 717 Section IV.F.9.
every 15 minutes documented		
on an observation log.		
Involvement of health,	Sections 1(7) and (8), 3	Policy 717 Section IV.E.9.h.,
including mental health,		F.2.–5. & 15.; Previous
professionals.		Regulation Section 1(7), (11)
Right of a child to normal	Section 1(9)	Policy 717 Section IV.F.7.;
living conditions and		Previous Regulation Section
privileges while in isolation.		1(14)
Requirement of the child to	Section 1(10)	Policy 717 Section IV.F.8.;
keep his or her room clean.		Previous Regulation Section
		1(15)
A continuum outlining the	Section 2	Policy 717 Section IV.E.9.;
steps for approval of		Previously Regulation Section
lengthening the time of		1(5)
isolation. <sup>46</sup>		
Documentation of everything	Section 4	Policy 717 Section IV.F.1., 5.,
that happens in isolation.		9.–11., 13.–14., 16., K.;
		Previous Regulation Section
		1(10)
Prohibiting the use of isolation	Section 5	Previous Regulation Section 5
as a means of suicide		
prevention.		

As discussed in the APA's report, DJJ definitely needs an isolation policy update. That can come with a regulation that, unlike the proposed regulations, tracks the CJJA Toolkit and JDAI

209 St. CLAIR STREET FRANKFORT, KY 40601-1817

TELEPHONE 502.564.5841
FACSIMILE 502.564.2912

<sup>&</sup>lt;sup>45</sup> To give credit where credit is due, Section 6(1) of the proposed regulation does now make it clear that DJJ cannot use isolation for protective custody. But this is essentially the only meaningful, positive change offered by proposed regulation 505 KAR 1:410E.

<sup>&</sup>lt;sup>46</sup> As described above, recall that a policy affording the use of isolation for more than four hours should not exist.

Standards. The totality of the regulation should be amended to incorporate recommended policy measures by those two sources of guidance.

But the other big issue is DJJ's execution of a use-of-isolation policy; a policy is only as good as its execution. It is unknown what the Beshear administration's plan is for ensuring that isolation protocol, even if properly outlined, is actually followed.

At bottom, the proposed regulations need to be amended to (1) track the standards for the use of isolation as outlined by JDAI Standards and the CJJA Toolkit and (2) outline a plan for ensuring that those standards are actually followed by DJJ staff. Without these measures, the proposed regulations are nothing more than a publicity stunt.

### II. 505 KAR 1:140E throws the baby out with the bathwater.

505 KAR 1:140E does only one thing—repeal DJJ Policy 717. As discussed, Policy 717 contained DJJ's rules on the use of isolation. But Policy 717 was not just about isolation. That policy contained many rules governing discipline and special behavior management within DJJ. The total repeal of Policy 717 appears to leave DJJ without any policies or procedures governing discipline and special behavior management within DJJ, apart from those about the use of isolation.

Consider first Section I. of Policy 717:

Discipline shall be administered to create a learning experience for the juvenile and shall not be administered to degrade or humiliate a juvenile. Alternatives shall be provided for out-of-control juveniles who require special behavior management. Special behavior management programs shall be individualized. Corporal punishment, the use of mechanical restraints, abuse, assault, personal property damage, harassment, the denial of meals or snacks, and the interference with daily functions of living, such as eating, or sleeping shall be prohibited as punitive consequences.

Those instructions dictated the strictures on DJJ's use of discipline across its eight juvenile detention facilities. But the repeal of Policy 717 eliminates those instructions with no known replacement. So the fear is that DJJ's eight juvenile detention facilities are now on their own to administer whatever kind of discipline they feel is appropriate in whatever way they want. This failure to give appropriate guidance to those facilities is the exact kind of marooning of DJJ by Beshear administration leadership that has contributed to and exacerbated the problems within DJJ over the last several years.

Consider what else the repeal of Policy 717 eliminates. Policy 717 contained the following prohibition: "Restraints shall not be used as a punitive consequence." With the repeal of Policy 717, there does not appear to be any other prohibition on the use of restraints as a punitive consequence. The repeal of Policy 717 also eliminates DJJ's development of an individual program plan for juveniles with "serious behavior problems." Finally, the repeal of Policy 717 eliminates DJJ's continuum of "acceptable disciplinary interventions or consequences." This continuum was essentially a list of acceptable disciplinary measures to be used before even

considering isolation. Again, with the repealing of all of these rules and the failure to replace any of them with new ones, it appears that the administration is endorsing the use of restraints, the elimination of individualized program plans for DJJ children, and the ability of DJJ's facilities to use whatever means necessary—no matter how damaging or barbaric—to discipline a child.

It is unknown what plan the Beshear administration has to ensure that none of this happens, as the repeal of all of the aforementioned parts of Policy 717 has not been replaced with anything. The administration must put in place rules governing DJJ conduct in the now-ruleless areas that exist with the elimination of Policy 717.

### III. Neither regulation addresses any of DJJ's problems.

On January 31, 2024, the APA released a 231-page examination report of DJJ identifying numerous problems needing fixing for the sake of the children and staff within DJJ's walls and the general public. More importantly, the examination suggested solutions for fixing those problems. But it appears the findings and recommendations of the examination have been completely ignored.

The proposed regulations do nothing to remedy the problems identified by the examination. As a reminder, these problems are as follows:

- 1) There is no evidence that DJJ has corrected any findings from the 2017 audit of it done by the Center for Children's Law and Policy. Of note are 18 unaddressed findings related to medical and mental health care for the children at DJJ.<sup>47</sup>
- 2) DJJ does not have appropriate policies and procedures on the use of isolation, and isolation is inappropriately used in ways that cause trauma and mental health damage to DJJ youth. 48 The Beshear administration has not explained how it will ensure that DJJ's eight juvenile detention facilities actually implement an appropriate use-of-isolation policy with fidelity.
- 3) DJJ's use-of-force practices have been a major problem, evidenced by its use of pepper spray at a rate of 73.9 times more than that used in federal adult prisons and the introduction of tasers that some experts believe should be banned.<sup>49</sup> There is no known solution put in place by the Beshear administration to remedy this problem, despite there being many offered in the APA's report.
- 4) Widespread confusion and lack of clarity exist about the implementation and execution of a behavior management model within DJJ.<sup>50</sup> A clear behavior management model in accordance with best practices prevents further trauma and damage done to DJJ youth, while keeping staff safe in implementing it.

<sup>&</sup>lt;sup>47</sup> APA Report at 1–2, 14–19.

<sup>&</sup>lt;sup>48</sup> APA Report at 1, 20–32.

<sup>&</sup>lt;sup>49</sup> APA Report at 1, 33–40.

<sup>&</sup>lt;sup>50</sup> APA Report at 1, 41–45.

- 5) A plethora of healthcare-related issues exist within DJJ.<sup>51</sup> Examples of such issues include chronic staffing challenges, poor workload balancing, a lack of consistent operational medical practices, and a problematic record-keeping and documentation system. These deficiencies negatively affect the physical and mental well-being of DJJ youth and the safety of DJJ staff.
- 6) The Beshear administration's move from a regional to a security-based detention facility model has negatively affected DJJ youth.<sup>52</sup> Children are farther away from their families, communities, and court. And this model has added more transports of children between facilities, which has negatively impacted these children's education and religious practices, among other traumatic effects.
- 7) The provision of education to youth within DJJ is inconsistent, poorly implemented, and lacks oversight.<sup>53</sup> Education can help set these children on a path toward success and should be prioritized.
- 8) Despite the Beshear administration's representations, DJJ remains chronically understaffed.<sup>54</sup> This endangers both the youth and staff within DJJ.
- 9) The Beshear administration has failed to ensure that DJJ staff are properly trained and retained.<sup>55</sup> An improperly trained and understaffed DJJ endangers both the youth and staff.
- 10) The Beshear administration lacks a unified strategic direction for DJJ.<sup>56</sup> This has left facilities operating on islands with no support from central command, leading to the persistent problems DJJ continues to face.
- 11) DJJ's policy manual is exceedingly confusing and disorganized and lacks clarity and consistency.<sup>57</sup> The failure to have a clear policy manual in accordance with best practices and one that is readable, understandable, and implementable by staff is what leads to the chaos within DJJ that it is currently experiencing.
- 12) DJJ lacks an effective quality assurance program that can identify and fix issues.<sup>58</sup> Like having the proper support from leadership, an effective quality assurance program would curb many of the incessant issues DJJ continues to face.

Neither regulation addresses any of these issues or even hints at a plan for addressing them. That needs to be rectified.

<sup>51</sup> APA Report at 1–2, 46–73.

<sup>&</sup>lt;sup>52</sup> APA Report at 2, 74–77.

<sup>&</sup>lt;sup>53</sup> APA Report at 2, 78–81.

<sup>&</sup>lt;sup>54</sup> APA Report at 2, 82–92.

<sup>55</sup> APA Report at 2, 93–98.

<sup>&</sup>lt;sup>56</sup> APA Report at 2, 99–101.

<sup>&</sup>lt;sup>57</sup> APA Report at 2, 102–13.

<sup>&</sup>lt;sup>58</sup> APA Report at 2, 114–21.

As Governor Beshear has said, "every child is a child of God and deserves the best." It's time his administration put politics to the side and do what needs to be done to fix DJJ. This will not only help the children and staff within DJJ. It will also help curb juvenile recidivism and poor reintegration of these children into society, both of which, if gone uncurbed, will only bring more pain to DJJ youth, their families, and the victims of their acts. We cannot allow that to happen and must do what is necessary to put these kids back on a path toward success.

Thank you for the opportunity to be heard.

Sincerely,

Allison Ball

Kentucky Auditor of Public Accounts

allisa Ball

<sup>&</sup>lt;sup>59</sup> Andrew Wolfson, *Unplaced children sleeping on floor of Kentucky cabinet's Louisville office*, The Courier Journal (July 8, 2023), https://www.courier-journal.com/story/news/2023/07/07/children-sleeping-in-office-if-kentucky-cant-place-them-in-foster-care/70392803007/.