COMMONWEALTH OF KENTUCKY
PERSONNEL BOARD

VICTOR HOLT (APPEAL NO. 2016-072)
AND REGINALD WINDHAM (APPEAL NO. 2016-074) **APPELLANTS**

VS.

FINAL ORDER
SUSTAINING HEARING OFFICER'S
FINDINGS OF FACT, CONCLUSIONS OF LAW
AND RECOMMENDED ORDER

FINANCE AND ADMINISTRATION CABINET **APPELLEE**

*** *** *** *** ***

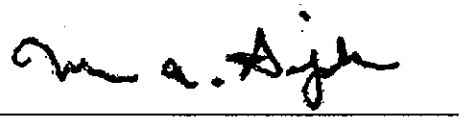
The Board, at its regular June 2017 meeting, having considered the Findings of Fact, Conclusions of Law and Recommended Order of the Hearing Officer dated April 27, 2017, and being duly advised,

IT IS HEREBY ORDERED that the Findings of Fact, Conclusions of Law and Recommended Order of the Hearing Officer are approved, adopted and incorporated herein by reference as a part of this Order, and the Appellants' appeals are therefore **DISMISSED**

The parties shall take notice that this Order may be appealed to the Franklin Circuit Court in accordance with KRS 13B.140 and KRS 18A.100.

SO ORDERED this 15th day of June, 2017.

KENTUCKY PERSONNEL BOARD



MARK A. SIPEK, SECRETARY

A copy hereof this day sent to:

Hon. William F. Codell
Hon. J. Clark Baird
Mr. Scott Whitaker

COMONWEALTH OF KENTUCKY
PERSONNEL BOARD
APPEAL NOS. 2016-072 AND 2016-074
(CONSOLIDATED)

VICTOR HOLT AND
REGINALD WINDHAM **APPELLANTS**

VS. **FINDINGS OF FACT, CONCLUSIONS OF LAW AND RECOMMENDED ORDER**

JUSTICE AND PUBLIC SAFETY CABINET
DEPARTMENT OF JUVENILE JUSTICE **APPELLEE**

****

This matter came on for an evidentiary hearing on October 19, 20 and 21, and December 16 and 21, 2016, at 9:30 a.m., at 28 Fountain Place, Frankfort, Kentucky, before E. Patrick Moores, Hearing Officer. The proceedings were recorded by audio/video equipment, pursuant to the authority found at KRS Chapter 18A.

The Appellants, Victor Holt and Reginald Windham, were present and represented by the Honorable J. Clark Baird of Louisville. The Appellee, the Department of Juvenile Justice, was present and represented by the Honorable William F. Codell of the Justice & Public Safety Cabinet's Office of Legal Services.

I. STATEMENT OF THE CASE

1. This case arises out of a tragic incident in which a young lady submitted into the custody and care of the Lincoln Village Regional Juvenile Detention Center in Elizabethtown, Kentucky, was admitted into the intake area, placed in an isolation cell, and, subsequently that evening, was found dead in the cell. An investigation into the incident disclosed numerous violations of the Department of Juvenile Justice (hereinafter referenced as "DJJ") policies concerning required bed-checks and room observations to be conducted of the youths placed in their care, particularly when they are secured in a cell or room. This incident occurred during the interim of political administrations controlling state government. The investigation of others involved, which appear to still be on-going at the time of the charges against these two Appellants, raised issues concerning the policy followed, in the procedures being utilized by the staff in overseeing the safety concerns of the residents in the Lincoln Village Center, and the process being utilized for documenting the safety checks. That procedural process is not in issue before this Hearing Officer, except to determine if it was a mitigating factor against the disciplinary penalty imposed on these Appellants.

2. The Lincoln Village Regional Juvenile Detention Center is operated by DJJ, and serves as a holding facility for youthful offenders from 14 counties. The youth are housed in the Lincoln Village Center where they are generally awaiting a pre-trial court order declaring their status as to trial or treatment, and where they are to be sent.

3. Victor Holt is a classified employee assigned as a Youth Worker Supervisor at the Lincoln Village Regional Juvenile Detention Center in Elizabethtown, Kentucky, operated by the Department of Juvenile Justice within the Justice and Public Safety Cabinet. He filed an appeal with the Kentucky Personnel Board on April 1, 2016 (2016-072), concerning his receiving notice by letter dated March 24, 2016, from Acting Commissioner LaDonna Koebel informing him that he was being placed on paid administrative leave pending a formal decision to discharge him. He was charged with numerous counts of poor work performance and misconduct arising out of an investigation into allegations of his failure to provide proper supervision of subordinate staff, adherence to departmental policies, and falsification of facility documents concerning bed checks and room observation of resident youths. Holt received formal notice from Acting Commissioner Koebel on April 13, 2016, confirming that he was being dismissed. Holt's appeal raised an issue that the facility was severely understaffed, that the staff was overloaded and overworked, and that the lack of departmental conformity and flexibility in the correction of deficiencies on the document packets concerning the supervision of the youth under their care made it impossible to have a system of uniform checks in the documentation, for which all the staff was punished or reprimanded.

4. Reginald Windham is a classified employee assigned to the Lincoln Village Regional Juvenile Detention Center as a Youth Worker Supervisor. He received written notice on February 5, 2016, from Acting Commissioner Koebel that he was being placed on administrative leave pending investigation into allegations of misconduct concerning his failure to complete required bed checks of the youths and falsification of the documentation of the supervision of the youth residents in the facility. Windham received a letter from Acting Commissioner Koebel on February 24, 2016, amended on March 7, 2016, that he was officially dismissed from his position with DJJ. Windham filed an appeal on April 4, 2016, submitting a letter dated March 28, 2016, in which he defended his actions arguing that DJJ policy caused the facility to be short on staff, caused the units to be out-of-ratio in the staff's ability to monitor all the youth housed in the facility, requiring the staff to engage in the practice of "catching up" on the documents, and causing the documentation to be incomplete, containing miscalculation of times of purported checks or even blank places on monitoring information.

5. By Order issued on May 27, 2016, by the Executive Director of the Kentucky Personnel Board, the appeals of Holt and Windham were scheduled for a Pre-Hearing Conference.

6. A Pre-Hearing Conference was conducted on July 20, 2016, on the consolidated appeals, in which the Appellants and their legal counsel appeared by telephone conference, and DJJ legal counsel was personally present. The consolidation of the appeals was confirmed by the parties and their legal counsel and noted in the Interim Order issued from the Pre-Hearing Conference. The Order also set the matter for an Evidentiary hearing to take place on October 19, 20 and 21, 2016.

7. The issue presented in the appeals was whether there was just cause for the dismissal of the Appellants and whether the penalty was excessive and erroneous. DJJ had the burden of proof, which was by a preponderance of the evidence. As the party having the burden of proof, had the right to proceed first in the presentation of the evidence.

8. The Evidentiary Hearing was conducted on October 19, 20 and 21, 2016, before E. Patrick Moores, Hearing Officer. Following the third day of hearing, the Appellants had not completed their proof, and the hearing had to be continued. The hearing was reconvened and the parties presented further evidence on December 16 and on December 21, 2016. Following the completion of the hearing, the legal counsel for the parties determined that they desired to submit written memoranda of their position on the facts and the law. Upon filing of their legal memoranda, the matter was submitted for a findings of fact and conclusions of law.

II. SUMMARY OF EVIDENCE PRESENTED

1. **James Thompson** was the first witness for DJJ, where he has been employed since 1998, and currently serves as a Juvenile Services Specialist for Region 3, which includes the Lincoln Village in Hardin County. He testified that on January 10, 2016, a young female youth was received in the intake area of the Lincoln Village, and the next morning, at approximately 10:19 a.m., was discovered dead in her intake cell. He said he and Bradley Marine, the DJJ Facility Regional Manager, went to Lincoln Village to investigate the matter and, while reviewing the documentation concerning 1) the monitoring of the room observations, 2) bed-checks done of the youths in the Center and 3) watching surveillance videos of the intake area, learned that Holt and Windham were the youth supervisors in charge.

2. Thompson testified that DJJ policy requires a staff member to visually observe each youth secured in a cell or room every 15 minutes, to look for any signs of distress and document the time of the bed-check and record any room observations on a DJJ form. The female youth in question was in an isolation cell in the intake area, awaiting a determination as to when she could be admitted for pre-trial processing, and was the only youth in the intake area.

3. The investigation revealed that Lincoln Village's policy was not followed in performing the required checks on the female youth and the documentation was falsified concerning the checks that were not performed. The investigation revealed that Holt and Windham failed to make the required checks, and wrote down that he did, whereas the surveillance video of the intake area showed that he did not. It further revealed he submitted a

false witness statement concerning the incident and his actions, which falsely stated the checks he conducted. As a result, a Request for Major Disciplinary Action was made by Thompson against Holt and Windham on charges of poor work performance, falsifying records, and misconduct.

4. Thompson introduced DJJ policies number 102, concerning the Department's Code of Ethics, and number 104, concerning the Code of Conduct. He testified that both Holt and Windham violated the Code of Ethics' honesty and integrity clause by falsifying their records, violated the Code of Conduct, Section IV.B., when they failed to perform the required bed checks but reported that they did, and violated Section IV.L. by being untruthful in their written documentation.

5. Thompson testified that the youthful female was in an isolation cell in the intake area, that DJJ policy mandated the room observation of the youth every 15 minutes, that the video disclosed that Holt and Windham failed to make the required bed checks and that they falsified the records that the checks had been made. He said that Holt filled out the forms that the checks had been made, but the Center's surveillance video revealed that they did not actually perform the checks and assess the decedent to determine her status or determine if she was fit for release from isolation.

6. Thompson testified that he also reviewed the Shift Reports and determined all shifts that day met the Federal Regulations staffing requirements for the number in youths being supervised at the facility. He further testified that he reviewed all of the documents for the accuracy required to maintain the integrity and security of the youths and staff, and that any failure to accurately document the status of each youth calls into question the integrity and ability of the facility to perform its mandatory duties. He concluded that Holt and Windham's dismissal was appropriate given the egregious nature of their failure to make the required checks and falsification of their documentation.

7. Thompson testified that the Youth Worker Supervisor is responsible for all the pods on the facility, and not just the intake area. Each youth must be directly monitored, and a video surveillance system is utilized through the entire facility to allow observation of the checks and any incidents. However, the video system cannot be used for "direct observation" on the room checks. Also, a staff member must be in the control room at all times and the Shift Report showed that it was manned and monitored at all times.

8. Thompson testified that a Youth Worker Supervisor has several duties, which primarily involve actual physical observation of each youth for their status on a regular timely basis and to make sure there is no issue with any youth in the residence pods. The supervisor also has to oversee each staff member to ensure everyone accurately performs their responsibilities and to make sure no pod is left unattended. Additionally, the supervisor is also responsible for all supplies and to make sure there are no issues with any of the jobs being performed by the staff.

9. Thompson described that a staff member is assigned to work as a "float," who is to assist and replace another staff member that needs to attend to a matter or to be on a break. Each employee gets two 15 minute breaks and a 30 minute meal break. Additionally, each staff has a lot of paperwork to complete, and he must spend time going through the documentation to ensure its accuracy.

10. Thompson testified their investigation revealed that the female youth was placed in an isolation cell because she was considered "non-compliant," resisting the efforts of the staff to work with her, and that she became physically combative. She was asked to remove her hoodie garment and refused. She even refused a snack. In terms of safety and security, it was determined that physical restraint was appropriate, and her combativeness was part of her refusal to cooperate. Accordingly, she was placed in an isolation cell in the Intake area. The times the young female youth was observed on the third shift, she was generally noted to be sleeping the entire third shift. The Lincoln Village Center SOP directs that youths should not be disturbed while sleeping, and it is appropriate that the supervisor refrain from waking up a youth to do an administrative review. Further, federal regulations prohibit a male officer from entering a female's cell unless an emergency exists.

11. Thompson testified that none of the room checks of the female youth revealed she had a blanket while on the bed, and the videos failed to show that she was in any kind of distress. There is no audio added to the video, so there is no way to determine if words were spoken. He commented on the Appellant's Exhibit Number 2, which was a copy of a field training module pertaining to a training performance checklist that Holt had previously provided a staff member, concerning conducting and documenting wellness and visual checks of youth residents. It clearly states, "These checks must be conducted anytime a resident is in a secured cell/room for any reason." In the steps for conducting the checks, it provides as the very first step to be followed: "Observe resident during sleep hours or when secured in a cell/room for any reason. These checks are completed within 15-minute increments." Thompson testified that the instructions to the staff member clearly showed that "Safety and Security are always the first priority," which Thompson said indicated to him that it is DJJ policy that the wellness of the youth must not be compromised.

12. Thompson also testified that the video showed that, prior to the young female being discovered deceased, Holt was eating a meal in the unit that they determined was rejected by a resident, in violation of facility policy that provides that staff are not permitted to consume food that is declined by a resident. DJJ Policy 114 requires that staff are to pay $2 for any meals consumed and the documentation revealed that the food Holt was eating was not purchased from the facility.

13. Thompson testified that he was not aware of any approved policy that permitted a process of "catching up" on incomplete forms with the date/time entries of bed checks or room observations. However, he stated that he believed that there was a pattern of such conduct being utilized among the staff as he did not believe it was possible to conduct all the required checks all the time. He stated that it may have looked good on paper, but it was not realistic. He

testified that as a result of a finding of this pattern of falsifying records that other disciplinary actions were taken with other supervisors and managers.

14. Thompson said he was not aware of anything the young female did to cause her death. He said it was his understanding that her death was the result of a congenital heart condition, and that the medical examiner found there was no criminal causation in her death. He was unable to express an opinion as to anything the Appellants could have done to prevent her death, other than their failure to make the required safety checks of her well-being, and their failure to comport themselves with the Code of Conduct.

15. **Michael Price** is DJJ Assistant Supervisor at the Lincoln Village. He has been employed with DJJ since 1999. He testified that any youth placed in intake means the youth cannot be placed in the general population, and that the youth must be checked every 15 minutes and that check must be documented on a room observation form. He added that a youth in isolation also must undergo an administrative review every four hours, except when the youth is sleeping.

16. Price testified that he has, from time-to-time, conducted random reviews of surveillance videos to make sure the staff is doing the required room checks. He also produced a copy of the minutes of a Supervisor's Meeting on October 18, 2013, on which Windham signed the attendance log, at which staff being responsible for bed checks of all residents was discussed. They also addressed the necessity of the time of the check be correctly recorded. Additionally, he produced a copy of the minutes of a Supervisors and Counselors Meeting, which both Holt and Windham signed the attendance log, where staff responsibility for bed checks was discussed along with the requirement that the time of the checks must be accurately documented. Price also disclosed that a Performance Improvement Plan had been issued to Holt on April 1, 2014, concerning corrective action to be taken by him on the safety and security issue of ensuring that his checks be conducted within the 15 minute window.

17. Price testified that he never received any comments from Holt or Windham that they did not have the resources to handle their work and perform the required checks. Price acknowledged that he had heard about some workers "catching up the checks," by falsely filling in the times of checks on the form, but that he never told anyone that they could skip conducting the bed checks. He stated if a youth worker could not check a room, it was not permissible to fill in the form with false information, adding that he did not consider it acceptable to turn in incomplete checks. He stated that it is important to do the bed checks within the required time to ensure the safety of the residents, as it only took five to eight seconds to check to see whether a resident was in bed and asleep or experiencing any distress. He added that he believed that one staff worker could conduct the 15 minute checks in all three pods. He testified that he had personally conducted training at the academy on how to conduct room checks within a required 15-minute window.

18. **Michelle Grady** has been a supervisor at Lincoln Village since 2010, with the responsibility of supervising staff and overseeing the safety and welfare of the residents. She testified that every employee is fully aware of the requirement that checks were to be conducted on a resident every 15 minutes, which is always emphasized in every meeting.

19. Grady testified that she reviewed the video of the deceased female's room and observed that Windham had not done the required checks. She said she prepared the requests for a Major Disciplinary Action. She said she never observed anyone telling employees not to do the bed checks or to write down false times for bed checks that were not performed. She said the staff had the necessary resources to allow them to do the required checks within the time allotted, and that anyone falsely completing the form was consciously making a choice to do something they were not supposed to do. She said the reason for the bed checks was to make sure each youth resident was safe.

20. Grady testified that it was not possible for a supervisor to inspect every document prepared by the staff regarding the conducting of their checks. She said she has been aware of document packets being returned to staff requesting blank information to be completed or marked as a late entry, adding that a supervisor could not force anyone to put false information on a form.

21. Grady testified that she was contacted by an investigator about the female resident's death, and that Bradley Marine asked her to prepare a complete Incident Report. She said she was grieved about the death of the young female resident, and that she had to talk about the young girl's death with her mother.

22. **Bill May** is a retired Navy Aviation Electronic Technician currently serving in DJJ as an Information Systems Supervisor, having the responsibility of maintaining and managing Lincoln Village's video camera system. During his testimony, he produced the video from the intake area showing that neither Holt nor Windham did the room checks of the deceased female resident that they alleged they conducted.

23. **Ed Jewell** is a Special Investigator for the Justice and Public Safety Cabinet. He was previously employed as a homicide detective with the Lexington Police Department. He said he was requested to investigate the circumstances concerning the young female's death, including why she was arrested, when was she brought to Lincoln Village, what paperwork was prepared concerning the incident, and what checks had been conducted on her. He said he interviewed and took statements from the staff, the police called to the scene, and from the coroner. He arrived at his conclusion and prepared an extensive Report, which was submitted on the record. He said his review of the surveillance video of the isolation cell she was placed in showed a significant discrepancy with the written room observation forms. He said the video established the times recorded on the forms of the alleged checks were incorrect.

24. Jewell testified that when he took a statement from Windham, he denied making any policy violations at first, but later admitted he was dishonest in his statement when he said he did all the checks. He concluded that on January 10 and 11, 2016, Windham conducted only five bed checks and missed doing twenty-five bed checks. He also did not complete the administrative reviews. Likewise, he found Holt was not honest with the investigators, did not conduct the bed checks, and fraudulently reported that he had done them.

25. Jewell concluded that the video and entries in the documentation of safety checks led to the conclusion that Holt and Windham did not follow departmental policy. He stated that he had investigated incidents of policy violations and that this is the most serious incident he had he had investigated. He further stated that the administration, supervisors and staff were not cooperative in the investigation. He stated that for example of the non-cooperation, he spoke with Ms. Grady on February 11, 2016, she stated that she thought the staff and supervisors did everything right, and that no documentation existed that would indicate the staff being responsible in the events surrounding the young female's death.

26. Jewell testified that he felt it was way too early in the investigation for her to have such conclusions. She further said she doesn't review the bed check logs, and that she did not know if videos are compared to the bed check logs. She told him that it is not necessary to enter the rooms to determine the wellness status of a resident, as they can observe their condition through the window. However, he said that Grady did not appear to have a good understanding of what was going on in her unit, and claimed she could not micro-manage the youth workers.

27. Jewell said he found that multiple staff members were not truthful about doing bed checks. He cited a statement given to him by Mr. Kimbler that he was too busy to compare the videos to the log to verify their accuracy. Kimbler acknowledged to Jewell that he may have missed some bed checks, but documented that he did them, stating that he only missed a couple of bed checks and that he tried to do his best. He told Jewell that when he reviewed the logs, he looked for completeness, not accuracy, and admitted that he did not supervise the staff the way the DJJ would like. Jewell said his investigation of the documented bed checks of the young female on the night of the incident disclosed that Kimbler reported he made the checks at 6:30 p.m. and 6:45 p.m., which was fraudulent.

28. Jewell said he determined that it was a common practice for the staff to record bed checks every 15 minutes, explaining this "common practice" was very frequent. He said that of the logs reviewed of 40 documented bed checks, 24 were fraudulent. Significantly, he reported that Windham informed him that when he was working in the control room, he did the bed checks by viewing the video instead of actually going and looking through the window in the door.

29. Jewell testified that that the video displayed in the control room is a flat screen 36 ½ inches by 20 inches, and provides a true and accurate depiction of the cells, in four rows of four views. He said you can see someone in the cell, but that the observer is unable to tell what the resident was doing or if there were any wellness issues that a personal observation at the door would reveal.

30. **Brent Kimbler** is a Youth Services Program Supervisor at the Lincoln Village. He testified that as a result of the death of the female resident and the violations of DJJ policies discovered in the investigation of the incident, he was suspended for ten days without pay.

31. Kimbler testified that the importance of the policy of accurate bed checks is repeatedly emphasized and staff are subject to disciplinary actions for violating the policy. He testified that Holt was placed on a Performance Improvement Plan (PIP) for failure to accurately conduct bed checks at the 15-minute requirement. He also said that Holt had recently issued PIPs to at least two staffers for their failure to make the 15-minute bed checks.

32. Kimbler also acknowledged that he had on occasion falsified bed check documentation, and that he is responsible when staff members falsify their records. He also stated that the packet of records on a youth resident are closed out when a resident comes off isolation or when the resident is given some other status. If the documentation is incomplete, the packet is returned to the staff worker who made the incomplete documentation for correction. He added, however, that they never tell anyone to falsify information. He emphasized this point by testifying about a recent email that Price had sent to all the staff concerning correcting blank information in incomplete documentation packets. He added, however, that he was more concerned about completeness of the records rather than their accuracy. He also stated that if a staff worker told him that the bed checks were performed, he would believe the worker. Kimbler testified that "waking" hours in Lincoln Village are generally from 5:45 a.m. to 8:30 p.m. during the day, during which residents are supposed to be somehow involved.

33. **LaDonna Koebel** is currently Chief of Staff for the Personnel Cabinet. She is also an attorney, and, in early 2016, she was serving as the Acting Commissioner for the Department of Juvenile Justice. She started at DJJ in 2005 as an Assistant General Counsel. She stated the controlling departmental policy involved in this matter is Lincoln Village's Standard Operating Procedure 709.12, the directive for "Security and Control, Resident Room Checks." She stated that Section IV of this SOP provides for the procedure to be followed, which states:

> Resident room checks are performed on a routine basis whenever a resident is in their assigned room, out of the direct observation of staff or under special circumstance requiring close observation in a room other than the sleeping room.
>
> Visual observation is always documented on the Resident Room Observation Sheet and/or Continuation Sheet.

> Routine random room checks are performed every 15 minutes unless circumstances require more frequent checks.

Koebel testified that her interpretation of this SOP required an "in person" visualization, and that the visual observation is to always be accurately documented. She said this did not allow the checks to be done by utilization of the video system, as the staff worker needs to be able to determine the resident's breathing and wellness.

34. Koebel testified that she became involved in the disciplinary process when she received a report of the allegations against the Appellants. She said a Request for Major Disciplinary Action came up through a supervisor in DJJ to the personnel department. She said she looked at the conduct involved, the severity and egregiousness of the consequences, and that her observations from reviewing the videos and documentation were that there seemed to be a lack of concern about the female resident who was the only youth in the intake area. She said that Holt did not appear to be overworked, and was more concerned with eating a meal. She testified that she reviewed hours and hours of video to confirm the failure of Holt and Windham to make the required bed checks. She signed the letters giving the notice of intent to terminate to Holt and Windham, stating that ultimately her decision came down to the conduct of failing to make the bed checks and the falsification of the records. She said she considered the falsification of the records to be critical to the decision to terminate when there is an incident of death, like what they were confronted with in this case. She stated that most custody deaths involve a suicide, but they were confronted with a death that involved the exact wellness and breathing issues that the safety checks are designed to prevent. She stated that she still stands behind the decision to dismiss Holt and Windham.

35. Koebel testified that the staff is trained to do personal observations and how to recognize signs of distress. She said the facility's SOP is directed to the implementation of the policy concerning the safety and welfare of the residents. She said that all the superintendents and staff are fully trained in the process of conducting the bed checks and the DJJ policy of visual observations, and that she has been personally involved in the training. She also said that the administrative staff is responsible to monitor the staff conduct and their adherence to the DJJ policy on a day-to-day basis. She said she learned that Kimbler acknowledged he did not check the accuracy of the times of the bed check monitoring, and that Price admitted not checking the packets to verify the checks were performed on the 15-minute intervals. She said every employee is responsible for applying the safety checks and documenting them accurately, and the supervisors are responsible for monitoring the application of the policy. She said she believed that supervisors should be held to a very high standard of compliance. She said she would have disciplined any supervisor telling staff members to falsify records, however, she had no evidence that any supervisor had told employees to falsify their records.

36. Koebel testified that she reviewed the entire investigation. She said she recalled that six persons were found to have falsified their records, and were disciplined, three of whom were terminated, including Holt and Windham. She said one falsification was too many, as no documents should be falsified.

37. **Robert Kennington** is currently retired, but had worked as a Youth Worker Supervisor at the Lincoln Village until he retired on August 1, 2013. He testified that Lincoln Village experienced large turnover because of the pressure they perform the safety checks and the packets which were sent back to correct deficiencies and fill in blank gaps in the documentation.

38. Kennington said that the SOP for conducting bed checks required the staff visually see flesh and signs of movement, such as breathing. If the resident's head was covered preventing observation, they would have to uncover the head. He said he oversaw staff observe the isolation cells in the intake area from monitors in the control room. He stated that staff had the approval from Mr. Price, a supervisor. However, he said a worker cannot see flesh or breathing from a monitor in the control room.

39. Kennington said that he would receive packets of documents on a resident, asking for details going back a month. He said if he wasn't working on a day they wanted corrected, he told them he could not and gave it back to them. He said it was essentially an impossible demand from the administrative office, as a worker could not go back and accurately say what was not known. He said no one ever directed him to falsify documents. He said further that he never falsely documented checks he performed. He said paperwork was always a hassle.

40. **Anthony Coffey** is a dispatcher for the Hardin County government and previously worked for Lincoln Village; leaving in 2016. He said he had returned packets of documentation on a resident for deficiencies, comprising incomplete progress notes and blank gaps on safety checks. He stated that if a youth was there several months, there would always be errors in the documents that would have to be corrected.

41. Coffey testified that after the death incident, everyone was retrained on conducting bed checks and documenting the times of the checks. He said the documentation had to be compliant with the American Correctional Association (ACA) and are required to be complete and accurate. He said the checks were not difficult, explaining that if he had ten guys residing in a pod, he could make all those bed checks in under a minute. He further stated that no one ever instructed him to write in a check when he was not there. If he had to fill in a gap he failed to document, if he did not know the answer, he said he would have to resort to reviewing the video to get the accurate information.

42. **Christopher Johnson** is currently working as a factory worker, but had worked at Lincoln Village approximately ten years until he was terminated in 2016 as a result of the investigation following the death incident, wherein it was discussed he had falsified some of the records on bed checks, and also getting caught eating a resident's meal, which the resident had refused to eat.

43. Johnson testified that there were several times the staff working in the control room were told by the supervisors to do the bed checks in the intake area using the video monitors when they were short staffed. He said that when a packet of documents were returned to them for correcting, many would be up to two to three weeks old, but some were up to six months old. He said the supervisor would hand them a packet and tell them to fill in the blanks on the checks. He stated that it was implied that they either filled in the blanks or they would be written-up on a disciplinary issue.

44. Johnson said the young female resident whose death initiated the investigation was brought into the intake area because she was not communicating or cooperating, and refused to be patted down or searched. He stated she kept saying over and over "I shouldn't be here."

45. Johnson said that he worked with Holt and Windham, both of whom he described as good workers. He said they were always short staffed making it hard to do everything needed. He stated that the staffing and documenting safety checks was a system issue, adding that there were times they did not have the time to do the checks due to all the administrative matters needing to be done. Johnson said he was taught how to do bed checks at the youth worker academy and was trained that they had to be done every 15 minutes.

46. Johnson said that on January 10, 2016, Lincoln Village was fully staffed and he was working as the "float." He said at 10:37 that evening in the intake area, the video showed that he and Holt spent 54 minutes between the checks. He said it would have taken 30 seconds to get up and check on the female resident in her isolation room.

47. Johnson further testified that over the decade he worked there at the Lincoln Village, he was told numerous times to fill in the deficiencies on the safety checks by the staff supervisors.

48. **Michael Atkins** is currently unemployed, having resigned his position as a Youth Worker II from Lincoln Village after working there from February 2005 until August 2016. He worked with Holt and Windham. He testified that Holt was the best supervisor he had worked for. He testified that there were many occasions that a supervisor would return a resident's document packet, telling them to correct the deficiencies by filling in the blanks. He said they would be told to make sure the blanks were filled out completely before he brought them back. He said he left his employment with the Center because of the staffing issues, as they never had enough staff and that he was not going to jeopardize himself the way Holt and Windham had. He said he felt it was time to move on. He said that he tried to rescind his resignation, but DJJ would not allow it.

49. Atkins said he was not on duty on January 10, 2016, and that he didn't know what happened. He said all the staff was trained about doing bed checks, and how they were to be processed. He said that at the Academy, they were taught to always look for a rising chest to confirm no breathing distress.

50. **Jeffrey Dean Wilson** is a Social Service Clinical Counselor I at Lincoln Village and worked with Holt and Windham. He often worked in the control room and often observed a youth in one of the isolation rooms on the video monitor. He said they were often understaffed and the staff would observe the youths and note their bed check status on the video monitors. He said he was not aware of anyone being disciplined for video observations, however, he acknowledged they could not observe a youth without actually looking into the cell/room.

51. Wilson said he attended the training academy with Holt and Windham, and worked with them "a lot," and that he never had any concerns or complaints with the performance of their jobs. Wilson testified that the staffing of Lincoln Village was very challenging. He said with three pods open, with up to ten youths in each pod, would require a staff member in each pod, one staff member in control, and one "floating" staffer. The floater has the job of providing each staff member two 15-minute breaks, in addition to covering for them on their dinner break. If they are short a staff member, or had no one as a floater, they face a very difficult situation performing all their duties.

52. Wilson said ACA certification is critical to the oversight process and the accuracy of the information in the documentation. However, he added that he had no clue if there were any ACA inspections of Lincoln Village. He said it was apparent to him that the most important issue to the administration is the completion of the document packets and the accuracy of the information provided on the records.

53. He said the term "catching up the checks" referred to incomplete information in the documents relating to the times and findings in the required bed checks and room observations. Wilson said such situations only happened occasionally, and that he didn't recall ever having to add a date or falsify the information. He testified that they would always hear reminders in the staff meetings where the supervisor would remind everyone to "do the checks." He said he was never told to skip a check or write down a check he did not do, and that it seemed apparent to him that management was very concerned about the accuracy of the checks. He further said that he was trained to do the checks of the youth by actually going to the cell and view the youth.

54. **Desiree Brown** has been employed at Lincoln Village as a counselor for 12 years and for the past year as a Social Services Clinician I, and worked with Holt and Windham, describing them both as excellent workers.

55. Brown testified that the resident that died was a youthful female in isolation with the door closed. She stated that a youth in isolation behind a closed door was a much different and more serious situation for the staff to monitor. DJJ policy required they be checked every 15 minutes, and that the documentation of the observations be written down truthfully and honestly. She said the isolation cell can be seen by the video monitor in the control room, but checks are not supposed to be done by video. She gave an example of times when she would miss a 15-minute check because she would be doing two or three jobs at once, working on the paperwork

of other residents that had been received in the intake area, which would, at times, cause her a delay in conducting the check, adding "but they are always in my sight" on the video monitor.

56. Brown testified that that the oldest group of documents in a packet returned to her for correction and completion was a packet on a resident that was one month old. The normal requirements were completions on progress notes, counselor notes, provide signatures, and fill in blanks on times and dates on checks.

57. She acknowledged her signatures on the minutes of a staff and counselors meeting on October 23, 2013, also attended by Holt and Windham in which the topic of discussion was that all staff are responsible for bed checks on all residents and the time of the check must be correct, and that all residents cannot have the same time on the bed checks.

58. **Donna Rae Walker** has been employed at Lincoln Village for the past three years as its Fiscal Manager, having responsibilities over the facility's budget, accounts payable, and vouchers. She also is responsible for putting together the ACA accreditation file and the documentation to go in the file, which she stores in a large file cabinet. She testified that she has returned many document packets for correction.

59. Walker testified that the youth workers are taught at the training academy that every document is to be verified by the worker. Department policy requires everyone to complete the documents honestly. She said that when the documents were sent back, if the youth worker said he did not remember when the event occurred, she just had to leave the information blank. She added that it would be impossible to go back and verify hundreds of documents they use by comparing them to video.

60. **Victor Ray Holt** worked at the Lincoln Village from July 2007 until he was terminated in March 2016. He said that he was complimented by his supervisor when he started that he "handled kids good," and, in 2011, he was promoted to a Youth Worker Supervisor.

61. Holt acknowledged that he had previously received disciplinary actions concerning paperwork violations. He stated that every time they had a youth on supervised watch, regardless of the shift, that two weeks to two months later they would receive packets of documents to correct and complete. He said they would then engage in "catching up the checks" to file in the notations and entries in the logs maintaining the 15-minute time checks. He was told by their supervisor, Mr. Price, that they must fill in the missing information concerning dates, times and progress notes. He said that management was more concerned about completeness over accuracy, stating that Mr. Kimbler always told him that the completeness was necessary for ACA so that they could get the funding for their budget. He said that the packet would have a cover sheet telling them what had to be done, and whatever corrections needed to be done were pointed out in the addendum to the forms.

62. Holt testified that they were allowed by Kimbler and Price to do their checks with the video monitors while they were working in the control room. He testified concerning an email they received from Kimber on December 14, 2015, a month prior to this incident, that "At no time is the control operator to do checks on youth in intake." The e-mail refers to some reviews of observation logs done by a staff member working as a control operator in the intake area, and states, "This does not need to happen again." Holt testified that the work environment at Lincoln Village consisted of too many tasks with insufficient staff. He said he did not agree with the administration that they had sufficient staff to do the assigned work with the number of residents at Lincoln Village, and he complained that management would often send the staff assigned as the "float" home to avoid paying additional compensation.

63. Holt said they were always short staffed on the third shift, and he stated that he did not believe DJJ policy specifically explained how the checks were to be done. He testified that the video monitors in the control room show the intake cells, and they can see if the resident is moving but they cannot tell if the kid is breathing from the control room monitors. He said that the youths were instructed not to cover up their heads when they are laying down so that the staff could verify they were breathing normally when they checked on the youths.

64. Holt also said that it was standard policy that the staff could eat the food that was declined by the residents, that the supervisors told them that they could go ahead and eat the food and not allow it to go to waste. He said they had to fill out a form that the resident refused the food, and that he never saw or heard of anyone disciplined for eating resident food. He said he was allowed two meal breaks, and that there was no rule that prohibited him from eating while on duty. Further, unless he is provided a break he may not leave his duty station.

65. Holt testified that he had problems with Kimbler, particularly with the way he was telling them what needed to be done. Adding to the pressure on Holt in trying to deal with Kimbler's criticisms was the emotional experience Holt was having with a close lady friend who was dealing with cancer.

66. Holt testified that on the date the young female died, he tried to talk to her on two separate occasions and explain that as soon as she became compliant and removed her hoodie and allowed a female staff member to search her, the sooner she would be able to leave the facility. He said the female resident kept telling him to get out of her room, and that she was not even supposed to be there. He said she even refused to eat any food or snack they offered her. He stated that he stood in the doorway talking to her and that she kept telling him to get out of the room, that she wanted to sleep and for him to leave her alone. He said DJJ regulations and the Prison Rape Elimination Act prevented him from entering her room except in the event of an emergency. He described her as noncompliant the entire time she was at Lincoln Village. Additionally, Holt admitted that he did not do the bed checks on the female resident even though he wrote on the report that he had.

67. Holt acknowledged that he issued PIPs to two employees concerning their not doing the 15-minute checks on a timely basis, and his signature on the PIP forms. He further identified the time check issue as a specific area that needed improvement. He also acknowledged a memo of counseling another staff member concerning the need to improve maintaining the 15-minute checks. In each of the corrective actions taken, Holt emphasized the requirement to adhere to the 15-minute check policy. Holt stated he did not like writing up the staff and beating them up with the matters he was told to do, when he stated that the "higher ups" were doing the same thing.

68. Holt testified that among the paperwork the staff was to perform was a professional review to obtain information about the youth. He said that his instructions were that if a youth was being noncompliant, he didn't have to do the professional review.

69. **Reginald R. Windham** started at the Lincoln Village in 2005 as a Youth Worker I, and was promoted over the years to the position of a Youth Worker Supervisor. He explained his work experience with Holt, saying he was one of the best supervisors at Lincoln Village. He also confirmed the testimony of Holt concerning the packets that would be returned to them for correction, and the emphasis they received that the forms were completed.

70. Windham testified that the bed checks required them to stand at the door of the room and observe the resident through the window in the door. He said that the video monitors in the control area permitted them to observe the resident in the room but they were unable to determine the welfare of the youth from the video monitor, as they had to stand at the doorway to actually determine the resident's condition.

71. Windham said that he had three breaks during his shifts, and that while most staff would leave the area during their break, the supervisors generally had to stay in the area because of the work needing to be done. Concerning the meals, he testified that there was no policy concerning the disposition of food that residents refused to eat, and that if the staff wanted it, they could eat it.

72. Windham said that in the decade he has been employed with Lincoln Village, he has had a total of three written disciplinary actions taken against him, one for using excessive force in 2006. He said he has also had PIPs issued on him. However, he testified that he didn't know of anyone being disciplined or fired for catching up the checks. He said it was a normal practice, and was required by the administration. He said when he went through his training at DJJ Academy, he was taught the requirements of the job and the requirements of the bed checks every 15 minutes. He said staff would be written-up for failing to make the 15-minute bed checks, and that he had been instructed to write-up staff, one of whom had missed a single check.

73. Windham described the 15-minute checks required them to walk to the door of the room of the resident, look in the window and observe the condition of the resident. He said the check would take less than thirty seconds. He agreed that observing a resident on the video monitor did not provide an ability to determine if the resident was breathing. In addition to filling out the checks on a resident, they would have to complete a Professional Review form on a resident to determine if the youth was ready to come out of isolation.

74. Windham testified that he was assigned to the Intake area on January 10, 2016. He testified that while he was working in Intake, he would be working on the computer filling out paperwork while listening to news and music on the radio. He said normally they would have the control operator watch any youths in the intake area, adding that the e-mail received from Kimbler a month earlier did not ban the operator from doing the checks, claiming that it was hypocritical of Kimbler to send that e-mail when he was guilty of the same conduct and that the chain of command allowed this to be done.

75. Windham admitted that the check forms indicated that he did the 15-minute checks when in fact he did not. A spreadsheet compiled on the checks showed almost two hours where the female resident was not checked. This was verified by the video, which showed one hour and 53 minutes of no checks being conducted on her. Windham said that he was working filling out paperwork, but admitted that he was not so busy that evening that he could not have checked on her. He said he did hear her get up and go to the bathroom and also cough, but that he did not see it.

76. Windham admitted that the safety of the youths residing in Lincoln Village was their primary objective and took priority over everything. He said that in view of violations of DJJ policy occurring all the time for years on a regular basis, even by his supervisor who is still employed at Lincoln Village, that he believed that he was being treated unfairly by the disciplinary action taken against him.

III. FINDINGS OF FACT

1. On January 10, 2016, a young female who had been placed in DJJ's Lincoln Village Regional Juvenile Detention Center in Elizabethtown, Kentucky, was discovered unresponsive the next morning in an isolation cell in which she had been placed, and was subsequently pronounced dead.

2. An extensive investigation was launched into the events surrounding the young female's death, in which statements were taken from all involved staff and supervisors, documentation of the care provided to her were collected, reviewed and analyzed, surveillance videos were reviewed and a report was issued of the findings. Based on that report, several staff and supervisors received disciplinary action, including three employees who were terminated from their employment with DJJ. Two of those employees that were terminated, Victor Holt and Reginald Windham, appealed the disciplinary action to the Kentucky Personnel Board.

3. An evidentiary hearing was conducted over the course of five days, in which witnesses were presented, testimony of the training the staff received concerning the oversight and care of the youthful residents once they were housed at Lincoln Village, documentation concerning the decedent was received, a surveillance video of the activity in the intake area in which she was housed was presented into evidence, and DJJ policies concerning staff duties and responsibilities in caring for the youthful residents were testified to and analyzed by the witnesses. A large amount of testimony was presented concerning DJJ's policies pertaining to the requirement for bed checks and room observations every 15 minutes, and the return of such records to the staff for follow-up completion of such records two weeks to two months after they are turned in by the staff.

4. The purpose of the 15-minute bed check as stated in Lincoln Village's Standard Operating Procedure #709.1, Section IV.B.3 is for "verifying the resident is safe and secured in the room and documented on the Unit Room Observation Sheet." The purpose as further explained in DJJ Policy #110, Section IV.7., is "to ensure the youth are breathing and are in no apparent medical distress."

5. The Department of Juvenile Justice Policy and Procedure 104, Section IV.B, provides:

> **Employees shall perform their work assignments competently and in a professional manner. It is the responsibility of each employee to know and act in accordance with Department policy and standard operating procedures.**

6. All witnesses agreed that DJJ spent significant time ensuring that all staff members were trained in the proper method of performing safety procedures on the residents, including bed checks during sleeping hours or the times they are restrained in a closed room. Further testimony was given about the constant reminders of the requirements for these checks at staff meetings, and the write-ups staff receive if they are found to have not completed the required checks.

7. Despite all the issues within DJJ concerning the failures of the staff to timely perform the bed checks, and the subsequent return of packets of documents to the staff two weeks to two months later to correct and complete the forms and the parts left blank, causing the staff to engage in falsifying the forms by a process known as checking the checks, the plain and simple truth is that a female resident in an isolation cell at Lincoln Village went one hour and fifty-three minutes in which no check was made on her. At some time, while housed in the isolation cell and for some unexplained reason, she died.

8. The true facts establish that the female resident was considered non-compliant in cooperating with Lincoln Village staff and, according to DJJ policies, was required to be placed in an isolation cell in the intake area, where she was required to be visually checked every 15 minutes to ensure that she was breathing normally and in no apparent medical distress.

9. The true facts establish that the female resident was in visible distress, angry and repeatedly saying she was not supposed to be at Lincoln Village, refusing to talk to the staff, refusing to remove her garment and be searched, and refusing all offers of food. The staff accommodated her wishes to be left alone to the extent that, once she was placed in the isolation cell and appeared to be asleep, they did not even bother to check on her condition for almost two hours, under the apparent notion of "let sleeping dogs lie."

10. The other plain and simple truth is that all the testimony received on the history of violations of DJJ policy in performing the checks is irrelevant and does not constitute any mitigation to the fact that for almost two hours she went unchecked. While it is unknown that had the young female been properly checked and observed during that time her life might have been preserved, it is clear that the violation of DJJ policy and failure to conduct the bed-checks denied the young female resident of every possibility that her life might have been rescued.

IV. CONCLUSIONS OF LAW

1. The facts establish that the Appellants, Victor Holt and Reginald Windham, failed to comply with DJJ policies concerning safety checks of residents and for almost two hours left a young female resident, who was in apparent distress, that resulted in her death.

2. The arguments on behalf of the Appellants that the history of violations of departmental policy in meeting the required safety checks and the falsification of the records of the checks do not mitigate against the facts that for a critical one hour and fifty-three minutes no checks were conducted. The investigation revealed that sometime between 11:39 p.m. on January 10, and 9:56 a.m., on January 11, 2016, the female died in her isolation cell.

3. The function of the services provided at this juvenile detention facility is very serious, not only to the families of the residents whose loved ones are placed in the facility, but also to the people of the Commonwealth who entrusted the youths to the staff of the facility to provide for the safety and welfare of the youths and provide their pay for its implementation. The duties and responsibilities given to the staff are reasonable and clearly documented by the legislature in the statutes and regulations, and by the Cabinet in the policies. The employees are trained and frequently reminded of these rules, which are not to be ignored.

4. The evidence produced during the hearing demonstrated that DJJ and the Lincoln Village Center have major issues with enforcement of their policies, particularly failed checks, and failure of supervisors to comply with their responsibilities. The investigation into this incident revealed that the staff missed and falsified sixty-five bed checks. However, that is not an issue in this hearing, and does not change the fact that had the bed checks been performed it might have helped discover her condition and saved the female resident.

5. This hearing officer believes, under the authority of 101 KAR 1:345, Section 1, *supra*, the Acting Commissioner of the DJJ must be allowed to exercise some discretion in determining the appropriate actions to be taken in disciplinary proceedings, particularly where it is shown that her decision was supported by sound decision on the evidence presented, and not in violation of the Department's policy or the laws of the Commonwealth of Kentucky.

6. After extensively reviewing five days of hearings, reviewing all the testimony and documentation, considering the arguments of counsel, and the laws of the Commonwealth of Kentucky, it is the conclusion of this Hearing Officer that the termination penalty imposed on the Appellants was appropriate and reasonable and taken with just cause.

V. RECOMMENDED ORDER

Having considered and weighed all the evidence and the laws of the Commonwealth of Kentucky, and based upon the foregoing findings of fact and conclusions of law, the Hearing Officer recommends to the Personnel Board that the appeals of **VICTOR HOLT (APPEAL NO. 2016-072) and REGINALD WINDHAM (APPEAL NO. 2016-074) VS. JUSTICE AND PUBLIC SAFETY CABINET, DEPARTMENT OF JUVENILE JUSTICE** be **DISMISSED.**

NOTICE OF EXCEPTION AND APPEAL RIGHTS

Pursuant to KRS 13.B.110(4), each party shall have fifteen (15) days from the date this Recommended Order is mailed within which to file exceptions to the Recommended Order with the Personnel Board. In addition, the Kentucky Personnel Board allows each party to file a response to any exceptions that are filed by the other party within five (5) days of the date on which the exceptions are filed with the Kentucky Personnel Board. 101 KAR 1:365, Section 8(1). Failure to file exceptions will result in preclusion of judicial review of those issues not specifically excepted to. On appeal, a circuit court will consider only the issues a party raised in written exceptions. See *Rapier v. Philpot*, 130 S.W.3d 560 (Ky. 2004).

The Personnel Board also provides that each party shall have fifteen (15) days from the date this Recommended Order is mailed within which to file a Request for Oral Argument with the Personnel Board. 101 KAR 1:365, Section 8(2).

Each Party has thirty (30) days after the date the Personnel Board issues a Final Order in which to appeal to the Franklin Circuit Court pursuant to KRS 13B.140 and KRS 18A.100.

ISSUED at the direction of **Hearing Officer E. Patrick Moores** this 27th day of April, 2017.

KENTUCKY PERSONNEL BOARD

MARK A. SIPEK
EXECUTIVE DIRECTOR

A copy hereof this day mailed to:

Hon. J. Clark Baird
Hon. William F. Codell