OFFICE OF THE STATE INSPECTOR GENERAL

Virginia Department of Juvenile Justice: Bon Air Juvenile Correctional Center

Performance Audit

December 2025

Michael C. Westfall, CPA
State Inspector General

Report No. 2026-AUD-007

COMMONWEALTH OF VIRGINIA
Office of the State Inspector General

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December 5, 2025

The Honorable Glenn Youngkin
Governor of Virginia
P.O. Box 1475
Richmond, VA 23219

Dear Governor Youngkin,

The Office of the State Inspector General (OSIG) completed an audit of the Virginia Department of Juvenile Justice Bon Air Juvenile Correctional Center. The final report is attached.

OSIG would like to thank Director Amy Floriano and her staff for their cooperation and assistance during this audit.

Sincerely,

Michael C. Westfall, CPA
State Inspector General

cc: John Littel, Chief of Staff to Governor Youngkin
Justin Vélez-Hagan, Deputy Chief of Staff to Governor Youngkin
Kate Stockhausen, Assistant Deputy Chief of Staff to Governor Youngkin
Marcus R. Anderson, Secretary of Public Safety and Homeland Security
Sonny Daniels, Deputy Secretary of Public Safety and Homeland Security
Senator Barbara A. Favola, Chair, Senate Rehabilitation and Social Services Committee
Delegate Marcus B. Simon, Chair, House Public Safety Committee
Amy Floriano, Director, Department of Juvenile Justice
Tabitha Dowtin, Internal Auditor, Department of Juvenile Justice
Staci Henshaw, Auditor of Public Accounts
Amy Atkinson, Director, Commission on Youth

Bon Air Audit

What OSIG Found

Evidence is Lacking to Ensure Visual Wellness Checks are Performed

Residents at Bon Air may need to be confined behind a secure door due to behavior or health issues. This would include residents on self-injurious behavior watch. While a resident is confined, the primary tools used to document resident wellbeing are the confinement monitoring forms and bound monthly logbooks maintained in each unit. OSIG reviewed 37 forms requiring wellness checks. There was no evidence wellness checks were performed in 27 (73%) instances.

Rehabilitative Outcomes are Compromised When Therapeutic Services Are Not Provided Timely

OSIG reviewed 22 residents' treatment records to assess if therapeutic services were delivered as required by their initial assessment. Fourteen of 21 residents (67%) did not receive the required substance abuse therapy, 14 of 22 residents (64%) did not receive the required aggression management therapy, four of four residents (100%) did not receive the required sex offender treatment, and 18 of 22 residents (82%) did not receive the required individual therapy.

Residents Enrolled in Educational Programs Were Late or Not Attending Class

OSIG reviewed attendance records for 25 residents during the 2024-2025 school year to determine if residents are attending class. Nineteen of 25 (76%) residents maintained attendance rates below 75% across all classes, with two of the 19 (11%) with an average attendance rate below 50%, and seven of 25 residents (28%) had at least one class that was never attended during the test period. In addition, 24 of 121 (20%) of the 25 residents' classes had an attendance rate of 50% or less.

Management concurred with 15 of 18 findings and plans to implement corrective actions from 12/31/2025 to 12/31/2026.

December 2025

HIGHLIGHTS

Why OSIG Conducted This Audit

The Bon Air Juvenile Corrections Center (Bon Air) houses residents between the ages of 14 and 20 who have been committed by the juvenile court system for crimes ranging from misdemeanors to felonies. As of October 29, 2025, there were 188 residents housed at Bon Air. OSIG was directed by the Governor's Office to conduct an audit of Bon Air. This audit was conducted to evaluate Bon Air's operations, adequacy of staffing, resident programming, and resident mental health services.

What OSIG Recommends

- Ensure visual wellness checks are conducted and confinement monitoring forms are properly documented and reviewed as evidence the checks were performed.
- Increase Behavioral Services Unit staffing levels to ensure adequate therapist coverage across all units and treatment programs.
- Develop and implement a contingency plan to maintain therapy coverage during staff absences or separations, such as the use of contract or part-time therapists.
- Ensure that all instructional staff are trained on proper documentation in PowerSchool and establish accountability for daily compliance.

For more information, please contact OSIG at (804) 625-3255 or www.osig.virginia.gov

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REPORT ACRONYMS

The following is an alphabetical list of acronyms used in the report. This page should be helpful in identifying what each acronym stands for.

Absent Without Official Leave (AWOL)
Balanced Approach Data Gathering Environment (BADGE)
Behavioral Services Unit (BSU)
Bon Air Juvenile Correctional Center (Bon Air)
Break Assignments (BAW)
Department of Juvenile Justice (DJJ)
Facility Wide-Positive Behavioral Interventions and Support (FW-PBIS)
Heating, Ventilation, Air-Conditioning, and Refrigeration (HVACR)
Housing Unit (HU)
Human Rights Coordinator (HRC)
Information Technology (IT)
Institutional Incident Report (IIR)
Juvenile Correctional Center (JCC)
Juvenile Correctional Specialists (JCS)
Office of the State Inspector General (OSIG)
Positive Behavioral Interventions and Support (PBIS)
Prison Rape Elimination Act (PREA)
Resident Advisory Council (RAC)
School Security Officers (SSO)
Self-Injuring Behavior (SIB)
Standard Operating Procedure (SOP)
Virginia Department of Corrections (VADOC)
Virginia Information Technologies Agency (VITA)

BACKGROUND

The Virginia Department of Juvenile Justice (DJJ) operates the Bon Air Juvenile Correctional Center (Bon Air), located in Chesterfield County. Bon Air is a secure facility with an operational capacity of 272 beds. As of October 29, 2025, it served 188 residents between the ages of 14 and 20 who have been committed by the juvenile court system for crimes ranging from misdemeanors to felonies. While residing at Bon Air, residents receive mental health and rehabilitative counseling services. Specialized treatment programs include substance abuse treatment, aggression management, sex offender treatment, and intensive therapeutic programming. Academic and career readiness training is provided by the on-campus Yvonne B. Miller High School where residents can earn a high school or equivalency diploma, as well as engage in vocational and skill-building programs.

Bon Air originally opened in the early 1900s as the Virginia Home and Industrial School for Girls. Over the next several decades Bon Air operated under different names and served many different youth populations. In the late 1990s the Department of Youth and Family Services was renamed DJJ, and its facilities became known as Juvenile Correctional Centers (JCC). Some historic structures still stand on the campus, but most of the facilities were constructed after the 1950s to house minimum and medium security offenders. In the early 2000s Bon Air was one of seven JCCs operated by DJJ; however, JCCs began to close in 2005 in an effort to reduce costs and transition DJJ towards a treatment focused approach. The last JCCs to close were Culpeper JCC (2014), which housed maximum security youths, and Beaumont JCC (2017). When Culpeper JCC ceased operations, its residents were transferred to Beaumont JCC. When Beaumont ceased operations, residents were transferred to Bon Air.

Beginning in 2014 and into 2016, DJJ began to develop and implement a significant transformation plan that has been overseen by three different directors. The transformation plan is updated annually and posted to the DJJ website. The transformation plan is achieved through the following strategic goals:

- Expand reentry vocational programs, workforce development, and mentoring to provide resources to encourage a positive path of returning to the community.
- Support successful community programs and create new initiatives that will address the current concerns of the Commonwealth.

- Build trust with law enforcement and judicial partners to ensure youth are placed in the best possible, most effective programs.
- Address the concerns highlighted in the 2021 JLARC report, which focused on recidivism for the most serious offenders.
- Create new resources to support victims and families – including those with Limited English Proficiency or disabilities – who have been impacted by violent crime.
- Provide access to appropriate and effective mental health services for all youth under the agency's care.

Since 2014 DJJ has undergone significant changes including consolidation to a single facility, challenges of the COVID-19 pandemic, and consistently high staff turnover. An OSIG analysis of Juvenile Correctional Specialists turnover from July 2021 to August 2025 found that more than half of all separations (56%) occurred within the first two years of employment, with nearly 43% occurring within the first six months. Additionally, Bon Air has recently experienced public attention related to resident experiences, and resident and staff safety. OSIG was asked to conduct an audit of Bon Air by the Office of the Governor.

SCOPE

The main audit scope covered DJJ's operations at Bon Air from July 1, 2024, through August 31, 2025; however, some data analytics included July 2020 through August 2025. OSIG also performed unannounced inspections between June and October 2025. Additionally, this audit was limited to Bon Air operations, adequacy of staffing, resident programming, and resident mental health services. The scope did not include audit work related to other DJJ services such as the Community Programs Division or Placement & Program Implementation Division.

OBJECTIVES

- Determine if processes are designed to effectively hire, train, supervise, and retain adequate staffing in accordance with industry standards for a juvenile correctional facility.
- Determine whether requests, to include medical, counseling, and grievances are properly tracked and managed by the facility.
- Determine if resident programs, to include schooling, counseling, vocational, and life and rehabilitation skill development, are effectively managed to support the successful societal reintegration of residents.
- Determine whether facility processes are in place to effectively manage and coordinate the operations of the facility 24/7.
- Determine whether the facility meets the current and future housing needs for residents, as calculated by DJJ.

METHODOLOGY

OSIG conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that OSIG plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions based on the audit objectives. OSIG believes that the evidence obtained provides reasonable basis for the findings and conclusion based on the audit objectives.

OSIG applied various methodologies during the audit process to gather and analyze information pertinent to the audit scope and to assist with developing and testing the audit objectives. The methodologies included the following:

- Conducted interviews and walk-throughs, and examined policies and procedures to gain an understanding of the audit area, assessing the processes for efficiency and effectiveness, to include:
    - Reviewing policies and procedures to identify processes currently in place.
    - Evaluating the efficiency of processes for logging/documenting operations.
    - Evaluating the effectiveness of processes for inputting data from paper sources.

- Comparative testing of paper logs/forms to digital systems (BADGE, PowerSchool) to evaluate the accuracy, efficiency, timeliness, and outcomes of operational processes related to:
    - Mental health treatment.
    - Special Housing.
    - Vocational programs.
    - School.
    - Resident movement through Bon Air.
    - Available space against population projections.
    - Payment to staff of overtime and premiums.
    - Products and extracurricular events available to residents through good behavior.
- Conducted resident and staff interviews to gain perspectives on safety and security.
- Conducted an employee survey to assess job satisfaction, supervisory support, and the potential causes of retention issues.
- Performed benchmarking and comparative analysis of employee compensation across units within Bon Air and other comparable corrections operations in the Commonwealth.
- Reviewed documentation related to incidents, grievances, and Internal Affairs investigations to determine if issues are documented and addressed accurately and timely.
- Compared Bon Air campus to industry standards to assess the long-term viability of the current operating status, environment, and facilities.
- Performed seven unannounced visits:
    - 1 Holiday
    - 2 Evenings
    - 2 Weekdays
    - 2 Weekend Days
- OSIG had staff members on site from June 23, 2025, through November 6, 2025.

COMMENDATIONS

COMMENDATION 1 – POSITIVE BEHAVIORAL INTERVENTIONS AND SUPPORT PROGRAMS

OSIG reviewed the availability and attendance of Positive Behavioral Interventions and support programs offered to residents such as:

- Events hosted as rewards for good behavior.
- Events sponsored by Bon Air management or community supports.
- Art or other enrichment programs.

OSIG identified ten incentive events hosted between July 1, 2024, and August 1, 2025, and found that they were generally well attended. Additionally, OSIG interviewed a sample of residents. Nearly all residents indicated that they were pleased with the events and that they intentionally saved points to attend. Residents particularly enjoyed "Something in the Water" (a summer water balloon event hosted in August 2024 and 2025) and the "Block Party" (a summer 'cookout' style party with games and music). OSIG encourages DJJ to continue holding incentive-based events, including looking for avenues to increase the number of events each year.

COMMENDATION 2 – HIRING EVENTS

During the course of the audit, DJJ and Bon Air hosted a number of hiring events, which appear to have assisted in recruiting a significant number of Juvenile Correctional Specialists. Additionally, DJJ worked with a recruitment agency to expand the reach of job postings. Data analytics testwork related to hiring trends reflected this increase in hiring during the latter months of the scope period. OSIG encourages DJJ to continue developing programs such as these to increase hiring and improve retention.

FINDINGS

FINDING 1 - EVIDENCE IS LACKING TO ENSURE VISUAL WELLNESS CHECKS ARE PERFORMED

Residents at Bon Air may need to be confined behind a secure door due to behavior or health issues. This would include residents on self-injurious behavior (SIB) watch. While a resident is confined, the primary tools used to document resident wellbeing are the confinement monitoring forms and bound monthly logbooks maintained in each unit. The confinement monitoring forms are used to document the visual wellness checks on residents behind a secure door. The forms include the name of the resident, date, unit number, and if checks are required more often than every 15 minutes. They also include the time visual checks were made, what the resident was observed doing (resting, standing at door, quiet, out of room and reason, meals, medications, medical observations, etc.) and the initials of the staff performing the check.

OSIG randomly selected 32 days between (July 2024 and August 2025). One unit was selected for each day to ensure that each housing unit was tested twice. For the days selected, 18 of the days had residents in special confinement. The confinement sheets were requested for those 18 days. Two wellness checks and up to one SIB resident was selected. The total number of confinement monitoring forms for these 18 days were 34 for 15-minute wellness checks and three for SIB. The following exceptions were noted:

- For one of 18 days the confinement monitoring forms could not be located.
- 27 of 37 (73%) confinement monitoring forms lacked evidence to ensure the checks occurred. (Per Bon Air, seven of the 27 residents were subsequently found to be out of their rooms during the lapses.)

In addition, the confinement forms do not require evidence of management review for verification that confinement monitoring is occurring as intended.

Virginia Administrative Code 6VAC35-71-1140 only requires visual checks at least every 30 minutes and more frequently if indicated by the circumstances. However, DJJ procedure VOL IV-4.1-2.04 Movement and Supervision of Residents requires visual checks every fifteen minutes. In addition, VOL IV-4.3-5.06 states: “Supervision Levels - The required frequency of staff observation of residents. a. Active Supervision - Supervision of residents by (1) security series staff or (2) non-security staff who are responsible for maintaining the safety, care, and well-being of residents, who shall be close enough to where residents are to provide a quick response should an incident occur. At no time shall more than 15 minutes lapse between periods when residents are observed.”

The Library of Virginia specific retention schedule number 777-0002 for DJJ Juvenile Correctional Centers states: "Operational Logbooks and Documentation. This series documents events and information related to residents, staff, and operations within the facility." This documentation should be retained for "3 years after audit." DJJ Procedure Vol IV-4.1-2.06 Logbooks states: "7. The housing unit staff shall document the following: …c. "SIB precaution on (resident's name)" marked with a highlighter."

Confinement monitoring forms are the only daily record of each individual resident's visual checks while confined behind a secure door on their units. Without the confinement monitoring forms documenting the visual checks there is no way to determine if confinement monitoring is properly performed.

Recommendations:

1. Ensure confinement monitoring checks are performed and forms are properly retained as required by the Library of Virginia retention schedule.
2. Ensure confinement monitoring forms are properly documented each time a visual check is performed. The documentation should include the time and initials of the staff performing the visual check.
3. Ensure logbooks identify SIB residents and any notes on significant events impacting those residents that should be communicated for other unit staff.
4. Develop a process to ensure that confinement monitoring forms are reviewed by a supervisor to ensure that all residents behind a secure door are properly monitored.

DJJ Management's Response:

Management conditionally agreed with the observation and agreed with the recommendations as follows:

While the Department agrees with the observations of the OSIG team, the Department would note that the gaps are documentation based and do not reflect or support a lack of supervision.

The Department has historically struggled with the technological and fiscal constraints limiting the ability to move written documentation processes to a more efficient and reliable technology based applications. The Department agrees that the facility age, condition, functional ability and resources granted to the Department remain the largest challenges to all service delivery. Insufficient resources to attract and maintain staff lead to a high turnover rate, and a higher number of new and learning staff. While we have made numerous efforts to address the challenges, the age of the building, available technology, and fiscal limitations remain outside the control of the Department. Over the past four years, monumental efforts have occurred to address vacancy rates, improved

services and programming for youth with the means granted to us. The Department has prioritized service delivery within the resources granted to it, and as such, documentation remains a struggle. However, the Department has recently prioritized highlighting the importance of accurate documentation to incoming staff, has implemented a field training team and staff trainings to ensure a supportive, coaching environment for staff.

The Department agrees that a review of the written testwork documentation does not establish sufficient documentation for determination. After receiving the testwork documentation reviewed by OSIG, Bon Air JCC staff viewed available video footage (limited due to video retention storage space) and other documentation (e.g., logbooks) for the dates, units, and residents noted and found that in 26% of the cases cited by OSIG lapses in time for the visual checks were due to the residents being out of their rooms (and therefore not requiring a visual check to be documented on the confinement monitoring form). The remaining lapses in documentation were not able to be cross referenced by the Department or OSIG due to footage retention constraints. Based solely on the information reviewed by OSIG without cross referencing against other available resources, the Department does agree that the documentation does not fully encompass the supervised activities of the youth. While the gaps in the documentation observed in the audit demonstrates a documentation error, because the staff should have documented that the residents left their rooms; it is important to note that the error in documentation does not reflect a lack of supervision.

FINDING 2 - REHABILITATIVE OUTCOMES ARE COMPROMISED WHEN THERAPEUTIC SERVICES ARE NOT PROVIDED TIMELY

Bon Air provides several therapeutic programs, including individual therapy, substance abuse therapy, aggression management therapy, and sex offender treatment. A review of 22 residents' treatment records in Balanced Approach Data Gathering Environment (BADGE) revealed inconsistencies in the timely and appropriate delivery of these therapeutic services. Specifically:

- Fourteen of 21 residents (67%) did not receive substance abuse therapy appropriately and on time.
- Fourteen of 22 residents (64%) did not receive aggression management therapy appropriately and on time.
- Four of four residents (100%) did not receive all the sex offender group treatment sessions as required.
- Eighteen out of 22 residents (82%) did not receive all the individual therapy sessions at least once every 30 days.

Residents receiving Substance Abuse and Aggression Management Therapy frequently experienced delays exceeding five months before treatment initiation, had gaps of two months (or more) where no treatment was occurring, or were marked as having completed treatment without attending all sessions. Specifically:

- Of the 21 in substance abuse:
    - 4 did not complete all sessions, yet were deemed as having to complete treatment program
    - 8 did not start until 5 months or more post admission
    - 3 had two month breaks between sessions
- Of the 22 in aggression management:
    - 7 did not complete all required sessions, yet were deemed as having to complete treatment program
    - 7 did not start until at least 5 months or more post admission
    - 3 had two or three month breaks between sessions

DJJ procedures have set, for Sex Offender Treatment, residents were expected to attend two group sessions weekly but did not. Additionally, as noted above, residents were not consistently receiving the required monthly individual therapy sessions, and those in Sex Offender Treatment were not being seen weekly as required in DJJ's procedures.

According to procedure (VOL IV – 4.4-6 *Mental Health Treatment Plans*), staff and treatment program manuals:

- Individual Therapy: Must occur at least once every 30 days, with a goal of once weekly.

- Sex Offender Treatment: Requires two group sessions and one individual session weekly, beginning upon the resident's admission and continuing through release.
- Aggression Management and Substance Abuse Therapy: Require completion of a specified number of sessions in accordance with each program's manual to be considered successfully completed.

Per Bon Air staff, the deficiencies are primarily due to insufficient clinical staffing within the Behavioral Services Unit (BSU). Numerous issues that were noted occurred during a period where two BSU staff members were on leave or had separated from employment, which significantly reduced service capacity.

By not providing therapeutic services in a timely and appropriate manner, treatment integrity and resident rehabilitation outcomes are comprised, potentially delaying progress, increasing the risk of behavioral relapse, and reducing Bon Air's ability to meet its clinical and rehabilitative mandates.

Recommendations:

1. Consider increasing BSU staffing levels to ensure adequate therapist coverage across all units and treatment programs.
2. Develop and implement a contingency plan to maintain therapy coverage during staff absences or separations, such as the use of contract or part-time therapists.
3. Enhance monitoring and oversight of treatment scheduling and documentation in BADGE to ensure therapy sessions occur at the required frequency.

DJJ Management's Response:

Management conditionally agreed with the observation and agreed with the recommendations as follows:

While the Department agrees with the observations of the OSIG team, the Department would note that the gaps are documentation based and there is nothing to indicate actual outcomes were impacted. Documentation alone does not provide important context to the import and flexible structure of mental health treatment and interventions. All DJJ procedures (not regulations) can be waived as necessary by designated individuals

For example, the BADGE documentation indicates that 4 of 4 did not receive all of the sex offender group session required. This is due to the fact those assigned to Level II SO treatment are not required to complete group therapy at the same frequency and intensity as those with Level I treatment. Most of their SO treatment is completed through individual therapy with supplemental groups added as deemed appropriate by their BSU. This was observed by the Department in a review of the treatment files of 2 of the 4

youth (50%) tested by OSIG. Additionally, behavior can impact the treatment milieu at times and could also be a factor in the dosage and duration of service delivery.
The Department did hit a period in which there were insufficient resources to support a second sex offender unit, so there was a delay in beginning their services. This resource deficiency has been addressed, and a second unit was opened in January 2025. Since that date, there has been no waiting list or delay in Sex Offender treatment services.
Contextually, while procedures dictate treatment to begin as early as possible, often there are barriers to successful initiation of therapy meriting an exemption. When a resident arrives at Bon Air, many of them are acting out behaviorally and are unable to participate appropriately in a group setting. BSU will then meet with them individually to address anger management, impulse control and other needs in order to get them to the point that they can enter group. BSU also has the option to balance release date and start dates for beginning group. In order for some groups to be successful, they need to be capped at a certain number of residents, depending on needs of the residents. These decisions are reflected in the Resident's Monthly CTST notes versus BADGE because it is a group discussion. This was observed by the Department in a review of the treatment files of 12 of the 22 youth (54.5%) tested by OSIG.

The Department implementation of ART and formerly of CYT (which has subsequently been replaced) differs from the program manuals. The required number of sessions has historically been adaptable to better account for the needs of the population. While seemingly inappropriate, a variance in the number of sessions for each resident is occasionally not fully reflected in BADGE due to the limited number of input boxes available. BSU tries to make treatment as individualized as possible and will select different ART groups that best meet the current needs of the group. This then may create confusion on BADGE because the groups are not being held "in order." Additionally, some residents may miss a group due to absences, or for safety reasons and they are made up individually with the BSU and this contributes to the groups being completed "out of order." This scenario was observed in a review of the treatment files in five of the 22 youth (23%). Finally, a review of the case files connected to the tested documentation indicated that some youth were actually transferred to an adult correctional facility, accounting for the gap in services.

The practical delivery of the Department programs, as well as the fluid nature of individualized mental health treatment can also substantially impact the rigid structure of the Badge documentation process. For example, reviewing the noted CYT session documentation deficiencies, CYT has anger management components that BSU has the option to skip if the resident is already assigned anger management. To address documentation of this decision, BSU has now been instructed to document in Badge that the session has been skipped due to the content being covered in ART. This was observed

in three of the 22 youth files. Additionally, in the delivery of the Sex offender treatment program, ART is integrated into the SO program and is not documented separately. This can lead to the appearance in BADGE that the service was not administered. The Department observed this scenario in 2 of the 22 youth files

Due to historic resource deficiencies, BSU has been forced to prioritize providing services over documentation in many cases. The treatment needs of committed youth are significant (98.8% of youth have an aggression management treatment need, 87.7% have a substance abuse treatment need, and 76.7% have significant symptoms of a mental health disorder, with 68.7% prescribed psychotropic medication at admission). Bon Air serves high-risk youth with high severity offenses in a therapeutic setting while maintaining a focus on rehabilitation and thereby, preserving public safety. BSU has maintained very high caseloads and as a result documentation on BADGE has struggled. BSU supplements BADGE with their own tracking systems and paper documentation of the sessions. In response to the discrepancies observed by OSIG, BSU has gone corrected many of the missing notes from BADGE and are working to create a better documentation process.

The Department appreciates the potential risks identified by OSIG in developing the recommendations. While we agree that improper or ineffective delivery of therapeutic services could lead to the speculated outcomes, we also noted that instances of the possible outcomes were not observed within the facility. The Department additionally agrees with the actual observations noted by OSIG of the documentation reviewed by same. The Department always prioritize treatment for each individual youth designed to successfully meet their needs.

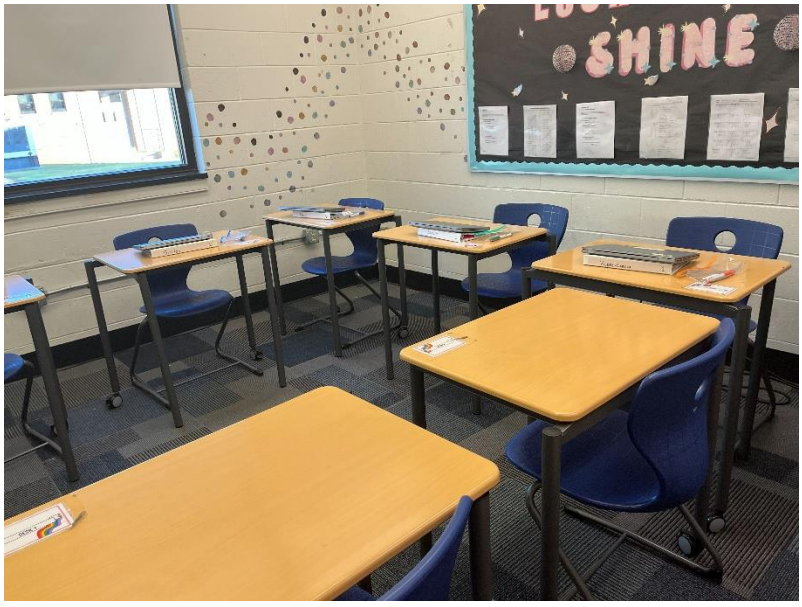
Several steps have already been implemented over the past four years to improve the quality of treatment for the residents at Bon Air. Implementation of a new evidence-based modality known as 7 Challenges was introduced to the facility to provide treatment to residents with significant substance use needs. Additionally, DJJ has created a new Behavior Assessment Unit which allowed resources to be reallocated, adding an additional psychology supervisor and doubling the number of therapists directly inside of BAJCC to primarily focus on treatment of the residents. Additionally, recent organizational structural changes have been made to move the Behavioral Services Unit under the Placement and Program Implementation division to ensure implementation science is being applied to enhance treatment services for the residents within BAJCC. The reorganization united the Behavioral Service Unit and Violence Intervention Unit within the facility to add additional resources and support. Furthermore, disciplinary action has been taken where appropriate and the process of recruitment and selection for unit leadership is currently underway.

Finally, it should be noted that of the 22 youth reviewed during the specified time period, some have since completed their identified treatment programs. A recent analysis determined that, under the 2023 guidelines, 95.9% of youth at Bon Air completed their aggression management treatment need and 93.6% completed their substance use treatment need prior to their late release date, indicating no extension in commitment length was necessary as a result of treatment delivery. More importantly, the majority completed their treatment prior to their early release date, 63.3% and 66.0% for aggression management and substance use, respectively.

FINDING 3 – RESIDENTS ENROLLED IN EDUCATIONAL PROGRAMS WERE LATE OR NOT ATTENDING CLASS

Residents enrolled in the educational program are required to participate in daily classroom instruction as indicated in *Code of Virginia* § 22.1-254. Attendance expectations at Bon Air align with academic standards that require sufficient instructional days to meet educational objectives and support progress toward graduation or vocational goals. Program administrators are responsible for ensuring that attendance and punctuality are accurately recorded in PowerSchool or other approved systems to demonstrate compliance.

OSIG reviewed a sample of 25 residents and their attendance records for the 2024–2025 school year to ensure that residents are attending class. *Code of Virginia* § 22.1-254. Compulsory attendance required; excuses and waivers; alternative education program attendance; exemptions from article states: "Except as otherwise provided in this article, every parent, guardian, or other person in the Commonwealth having control or charge of any child who will have reached the fifth birthday on or before September 30 of any school year and who has not passed the eighteenth birthday shall, during the period of each year the public schools are in session and for the same number of days and hours per day as the public schools, cause such child to attend a public school or a private, denominational, or parochial school or have such child taught by a tutor or teacher of qualifications prescribed by the Board and approved by the division superintendent, or provide for home instruction of such child…" It further states: "The requirements of this section shall apply to (i) any child in the custody of the Department of Juvenile Justice or the Department of Corrections who has not passed his eighteenth birthday."



Example of Yvonne B. Miller High School Classroom at Bon Air

While we found that residents attended class, attendance consistency and punctuality are not uniformly maintained across the student body. High rates of missed and late classes were observed, with significant variation between residents and subjects which suggests a systemic issue with attendance management, and not merely isolated student behavior. The table below contains a summary of these results.

Attendance and Tardiness of Sampled Residents

Resident	Attendance Rate	Tardiness Rate
1	57%	16%
2	50%	13%
3	91%	18%
4	90%	28%
5	44%	4%
6	77%	13%
7	75%	0%
8	54%	24%
9	80%	10%
10	74%	40%
11	65%	9%
12	43%	27%
13	68%	42%
14	75%	0%
15	83%	32%
16	70%	36%
17	65%	15%
18	85%	0%
19	89%	39%
20	57%	2%
21	82%	10%
22	64%	23%
23	67%	15%
24	88%	21%
25	91%	3%
Average	**71%**	**18%**

Further details from the testing include:

- 19 of 25 residents (76%) maintained attendance rates below 75% across all classes, with two of the 19 residents (11%) with an average attendance rate below 50%.
- 16 of 25 residents (64%) had at least one class where attendance was 50% or less.
- 24 of 121 (20%) of the 25 residents' classes had an attendance rate of 50% or less.
- Seven of 25 residents (28%) had at least one class that was never attended during the test period.
- 18 of 25 residents (72%) were late to at least 20% of sessions in one or more classes.

Further, during the on-site review of two classrooms, all ten residents observed arrived late; however, none of these instances were documented in PowerSchool, suggesting that this number may be higher if reporting was accurate.

Resident movement and logistical inefficiencies appear to be primary contributors to students' punctuality. Movement to and from class is often delayed, due to the overall movement process, which is further exacerbated by untimely unit releases or late lunch service, resulting in residents missing portions of the instructional periods. For example, during one observation by OSIG, morning class dismissal began at 10:45 a.m. and concluded at 11:26 a.m. (a 41-minute process). Lunch trays were called for at 11:10 a.m., reached the units at 11:24 a.m., and the last trays were delivered at 11:35 a.m. Afternoon class movement began at 12:25 p.m. – 40 minutes after the scheduled start – and concluded at 1:27 p.m., resulting in a total movement time of 1 hour and two minutes.

Additionally, resident attendance is affected by other factors including behavioral issues, court appearances, and room confinement. Many residents in correctional education settings face barriers in general, such as learning gaps, disabilities, and limited resources. The majority of youth admitted to Bon Air in FY2024 (93.1%) exhibited at least one symptom of ADHD, conduct disorder, oppositional defiant disorder, or substance use disorder, as stated by the DJJ Director in a presentation to the Commission on Youth. These challenges, combined with issues involving resident movement, contribute to the frequency of absences and lateness.

Inconsistent attendance and tardiness diminish residents' access to learning opportunities, hinder educational progress, and may lead to noncompliance with state academic standards. Incomplete or inaccurate attendance documentation limits Bon Air's ability to correctly monitor engagement, identify systemic barriers, and ensure accountability in its educational program.

Beyond compliance, poor attendance and engagement can have broader implications for rehabilitation outcomes. Studies from the Center of Public Justice show that access to quality education reduces recidivism among youth offenders. Conversely, residents with learning gaps, behavioral challenges, and limited educational support are statistically more likely to reoffend and less likely to achieve successful reintegration.

Recommendations:

1. Ensure that all instructional staff are trained on proper documentation in PowerSchool and establish accountability for daily compliance.
2. Engage educational, clinical, and security staff to identify and mitigate barriers to attendance and punctuality, including behavioral and scheduling challenges.

3. Generate and review periodic attendance and punctuality reports to detect trends, implement corrective action, and promote continuous improvement in educational engagement.

DJJ Management's Response:

Management did not agree with the observation but agreed with the recommendations as follows:

We disagree with the finding, as the cited attendance inconsistencies occurred exclusively during state-mandated testing periods in Marking Period 4, when normal class schedules did not apply; therefore, the finding does not accurately reflect our attendance practices.

During our review of the findings, we identified an oversight related to attendance documentation for a subset of students. Specifically, 8 of the 25 students identified as having inconsistent attendance enrolled in our school during April, which marked the beginning of Marking Period 4.

This period coincided with the Career and Technical Education (CTE) credentialing and Standards of Learning (SOL) testing window, during which students did not attend their regularly scheduled classes due to testing requirements and adjusted schedules. A daily reminder is issued by administration at 2:30 p.m. to ensure compliance, and administrators monitor attendance completion rates.

Testing Dates for SY 2024–2025:
• CTE Testing: April 7–18
• SOL Testing (Writing): April 7–18
• SOL Testing (Non-Writing): April 21–May 16
• SOL Retakes: May 12–16
• School Year Ended: June 6

While classroom sign-in sheets were used for attendance during the 2024-2025 school year, attendance is now entered directly into PowerSchool by the teachers for the 2025-2026 school year. Only substitute teachers use sign-in sheets and those are entered into PowerSchool by the School Attendance Clerk. The School Attendance Clerk is a new position that began in July 2025 in order to address identified attendance issues.

It is important to note generally that the classroom size (maximum of eight students) is significantly lower than in public schools and provides for more individualized instruction to students.

Movement is a continually evolving collaboration between almost all units on campus. Last school year (SY 2024-2025) was the first year that the students were back in the classrooms since before the COVID-19 pandemic. With the addition of returning to in-person dining this school year (SY 2025-2026) for breakfast (returning for lunch is in the planning stages), we are once again relearning processes to improve the experience for our residents

FINDING 4 - VOCATIONAL AND POST-SECONDARY PROGRAMS ARE OFTEN UNAVAILABLE TO RESIDENTS

Vocational and post-secondary program courses are intended to develop useful skills for residents and are a sentencing requirement for some residents. As of October 8, 2025, post-secondary vocational course offerings consist of Heating, Ventilation, Air-Conditioning, and Refrigeration (HVACR), Carpentry, Electrical, Plumbing, and Barbering. The HVACR class is scheduled to start again in the spring semester and was offered in the first semester of the 2025-2026 school year. They are currently advertising for plumbing and electrical instructors. Other post-secondary vocational programming includes Quilting and Upholstery and Culinary Arts.

OSIG reviewed course selection and course enrollment information in PowerSchool to determine what vocational and post-secondary programs were available during the 24-25 school year. Additionally, auditors conducted an unannounced site visit to observe class and reviewed current attendance information in PowerSchool to determine what courses were available. At the time of testing, three of the seven courses were not in session because no instructor was available.

High School students also have the opportunity to participate in vocational courses as well or engage in other Career and Technical Education programming such as Economics and Personal Finance, Military Science, Advertising Design, Digital Applications, or Design Multimedia & Web Technologies. Resident enrollment priority is based on individual resident's Length of Stay tier. Length of stay requirements are maintained, but program leadership indicated that there are more residents with vocational requirements than available seats; due to this, course waitlists are not used. However, once the prioritization needs are met other students are provided an opportunity. There was no indication that management knows which residents are interested. Vocational and post-secondary programming is often unavailable to residents due to insufficient staffing.

Virginia Administrative Code 6VAC35-71-740. Structured programming states:

> A. Each facility shall implement a comprehensive, planned, and structured daily routine, including appropriate supervision, designed to:
>
> 1. Meet the residents' physical and emotional needs;
> 2. Provide protection, guidance, and supervision;
> 3. Ensure the delivery of program services; and
> 4. Meet the objectives of any individual service plan.
>
> B. Residents shall be provided the opportunity to participate in programming, as applicable, upon admission to the facility.

While these outcomes were not observed, insufficient program availability and limited staffing could prevent residents from developing meaningful skills for use after their sentence or may

prevent residents from meeting structured programmatic goals outlined in their service plan. In addition, Bon Air houses residents whose sentencing requirements may include completion of vocational and/or post-secondary programs and if the courses are not offered or available, the residents may not be able to meet these requirements.

Recommendations:

1. Hire instructors to support vocational and post-secondary programs.
2. Develop and implement processes to retain qualified educators and expand available educational offerings.
3. Ensure that Bon Air is tracking and coordinating all vocational services offered.
4. Properly track resident sentence requirements for vocational training in addition to seniority, date of request/interest by residents, and other determining factors as part of developing a waiting list to track future demand for vocational courses.

DJJ Management's Response:

Management agreed with the observation, disagreed with the finding, and agreed with the recommendations as follows:

The Department agrees that OSIG did not observe a negative outcome to the potential risks, however, we agree that the potential risks are always something to monitor.

Vocational programs offered through the department are the only rehabilitative program (apart from PBIS) available in Bon Air that studies have shown an actual reduction in recidivism for youthful offenders. As such, it is vital that these programs be available and all resources available be dedicated to complete and supported implementation. The Department has instituted many processes that allow for review and adjustment to any barriers in the completion of these programs. For example, a waiver process has been developed and implemented for youth that cannot complete the programs due to age or other potential barriers. Tutors have been hired, alternative program pathways have been developed, and adjustments made to the LoS to allow time for completion. We have additionally partnered with employers in the community for training opportunities and employment opportunities for returning youth. Of note, we have even partnered with Dominion Virginia Power in a groundbreaking agreement for youth employment.

While we agree with the factual observations, we do have some points of conflict to be considered, as follows:

Current Offerings:

Post-secondary education at Bon Air goes beyond traditional trade courses. Our programs include a wide range of enrichment activities, industry certifications, and college-level courses designed to meet diverse student interests and career pathways. Currently, our

offerings include: Art, Military Science, Heavy Machine Operator, Advanced PE, Barbering, Quilting, Upholstery, Music Production, Carpentry, the Evening Electrical Program, Culinary Arts, and the Reynolds College Career Studies Certificate in Small Business and Entrepreneurship.

DJJ has been in continuous recruitment for HVAC and Plumbing instructors and additional Electrical instructors. HVAC and Plumbing courses are expected in Spring 2026, with interviews for candidates scheduled in November 2025. Moreover, we maintain an active partnership with the Community College Workforce Alliance (CCWA), which enables us to provide several industry-recognized certification courses such as Microsoft Office Specialist (MOS), CompTIA A+, Flagger Certification, Certified Logistics Associate and Technician, Manufacturing Technician, and OSHA 10.

Staff Recruitment & Retention:

Most of our post-secondary instructors are highly experienced and demonstrate long-term commitment to our program. Retention among this group remains strong. However, like many school divisions nationwide, we continue to face challenges in recruiting trades professionals directly from the workforce. The primary barrier, as documented by national organizations, is salary competitiveness. This issue affects Career and Technical Education (CTE) and vocational programs broadly and is not unique to DJJ. Reports from the Association for Career and Technical Education (ACTE) and the U.S. Department of Education confirm that shortages of qualified trades instructors are a widespread concern across the education sector.

FINDING 5 - INEFFICIENT RESIDENT MOVEMENT IMPACTS COORDINATED ACTIVITIES

Resident movement through Bon Air is inefficient, which causes residents to be late for school and post-secondary programs, dining, recreational activities, etc. Additionally, video monitoring of resident movement is fractured between two video systems, RapidEye and Ocularis, with only Ocularis being viewable from the "command center" where movement is coordinated.

OSIG conducted five unannounced site visits to observe resident movement and assess the security of movement per DJJ Procedure VOL IV - 4.1 - 2.04 section 4.2 (Supervision during Resident Movement). The policy was last updated in 2018 and does not reflect current processes, including involvement of School Security Officers (SSOs) and communication with/to central command.

During one of the visits, OSIG observed movement from three classrooms. Bon Air's intentional schedule shows school is in session on Monday, Tuesday, Thursday, and Friday and that each school day consists of two three-hour blocks with two periods each. Per the intentional schedule, the first block runs from 7:45 a.m. to 10:45 a.m. and the second block runs from 11:45 a.m. to 3:00 p.m. OSIG also obtained a school specific schedule which includes a 30-minute transition period at the start of each block and a 30-minute transition period at the end of the first block. With this taken into consideration, students are scheduled to be in class and leaning from 8:15 a.m. to 10:45 a.m. and 12:15 p.m. to 2:45 p.m. for a total of five hours of educational time.

During classroom observations, no students arrived to class prior to the end of the 30-minute transition period. The least tardy student arrived to class seven minutes late and the tardiest student arrived 59 minutes late. The earliest a resident left class was at 10:30 a.m., fifteen minutes prior to the transition time, to undergo a security screening before returning to their unit. The earliest a resident left without needing to undergo a security screening was at 10:38 a.m., seven minutes prior to the transition time.

During three of the five visits, OSIG observed movement from "central command" and the "shift commander's office." Both areas have multiple screens displaying multiple cameras across Bon Air; however, "RapidEye" cameras are only viewable on one of the shift commander's personal computer.

During one of those three visits, OSIG observed dismissal from the first school block, and movement to the second block. Morning (first block) dismissal began at 10:45 a.m. and concluded at 11:26 a.m. (a 41-minute process). Lunch trays were called for at 11:10 a.m. and began to reach units 11:24 a.m. The last trays were delivered at 11:35 a.m. Movement to class began at 12:25 p.m. (40 minutes after the time indicated on Bon Air's schedule) and concluded at 1:27 p.m. In total, movement from lunch on the unit to school took slightly over one hour and

resulted in the last student arriving to class one hour and 42 minutes after the time indicated on Bon Air's schedule and one hour and 12 minutes after the end of the transition period. During other visits OSIG observed unit movement to recreation, movement of dining trays to unit for dinner, and movement of residents to the "incentive room." Each visit demonstrated that movement is logistically difficult and time consuming.

OSIG conducted interviews with a sample of residents. Most of the interviewed residents noted that movement was slow and resulted in arriving to school late and meals arriving to units late. Notably, many of the interviewed residents indicated that food often arrived to units cold. However, most of the residents also stated that problems with movement had improved with the hiring of School Security Officers (SSOs) and increased staffing.

Movement is delayed by multiple factors:

- Infrastructure
    - Some buildings on Bon Air campus are very old, with original construction beginning in the early 1900s. The "existing" campus is approximately 75 years old and includes B-cottage, units 53 through 59. Units A2 through A4 are freestanding buildings, disconnected from the school and the main portion of Bon Air (referred to as "expansion). The expansion consists of the main entrance, medium security structure on the campus. It houses units 61 through 69, some classrooms, a dining hall, office spaces, a gymnasium and enclosed outdoor basketball court, and other facilities.
    - The age of the technology in these buildings impacts the efficiency of movement. All of the doors in the existing campus have physical lock and key and are not connected to the door control system in central command. Additionally, camera views of these buildings are not accessible from central command. Because of these physical limitations, central command can only control movement using radio communication. DJJ has recently completed a project installing fiber lines at Bon Air, which could be used to improve camera visibility.
    - DJJ facilities staff indicated that Bon Air is built to house minimum to medium security offenders. Changes have been made to enhance security, such as more secure fencing, but, due to the age, the buildings are not built to modern correctional standards and lack the physical tools and technology to fully secure pathways when moving residents. The expansion has security tools, such as controlled doors, that can be used to segregate residents and 'hold' movement in sections, but the design of the older portion of Bon Air prevents the development of modern secured pathways.
- Distance between units and school
    - Residents residing in B-cottage and units 53 through 59 are physically closer to the school. As a result, those residents often arrive to class before residents from

the expansion. However, some of those units are far from the "A" unit where some vocational programing is housed. DJJ and Bon Air staff take this into consideration when organizing movement, but the number of residents moving, the number of available staff, and the spread of buildings across campus creates logistical issues that slow movement.
    - Units 61 through 69 are housed in the "expansion." The expansion has better infrastructure for securing movement but is geographically far from the school. Additionally, while the resident placement processes do not include a formal risk assessment, many of the residents housed in the expansion are higher security than the existing units.
- Logistical
    - The level of preparation before a move varies between units, JCS officers, and residents. JCS officers are expected to secure residents who are not moving and to line up residents who are moving. However, not all JCS' officers coordinate the residents prior to movement by securing the residents. In addition, JCS officers and other housing unit staff have to work with residents who may be uncooperative. As a result, when central command calls a unit to move, the staff and residents spend additional time before the SSO or JCS can initiate the move.
    - There are not always sufficient staff to move residents. When this occurs, another staff member (such as a Housing Unit Coordinator or Shift Commander) has to move between units to facilitate movement. This is particularly relevant when moving to school as SSOs must be available to move residents from units and to stay with residents in classrooms.

Recommendations:

1. Review and update operational procedures related to resident movement to reflect current operations and to include processes designed to optimize resident movement using available tools such as controlled doors, resident staging, and communication where applicable.
2. Identify and assess the feasibility of infrastructure improvements that, along with process improvements, may enhance the safety, efficiency, and operational consistency of resident movement.
3. Ensure that Bon Air staff are trained on how to efficiently and safely prepare for and facilitate resident movement.
4. Hire and retain sufficient staffing to facilitate resident movement.

DJJ Management's Response:

Management conditionally agreed with the observation, and agreed with the recommendations as follows:

The Department agrees that the facility age, condition and functional ability remain one of the largest challenges to service delivery. While we have made numerous efforts to address the challenges, the age of the building, available technology, and fiscal limitations remain outside the control of the Department. Over the past four years, monumental efforts have occurred to address movement challenges, including the creation and implementation of the School Safety Officer unit, coordinated leadership efforts between the Education and Rehabilitative Care divisions, and cross training staff for movement support.

Some aspects of movement cannot be addressed purely through improved efficiency. Gang affiliation, known enemies, and co-defendants who need to be moved separately can cause varying levels of slowdown depending on the number of units affected. Beginning this school year, the residents are back in the dining hall for breakfast and dinner, which changed how movement needed to occur and as part of that adjustment, all available staff has been asked to assist. As the school year progresses, we continue to assess and improve how the staff is utilized. Education staff has made adjustments for remediation of any loss of class time, concentrating on make up and individual instruction as necessary every Wednesday, winter break, spring break and intercession.

We would note, however, that even with the challenges with movement, the facility has been able to go back to in person school full time and re-opened the dining hall after years of closure. We would further note that 2023-2024 School year demonstrated a 12% increase in graduation rates for committed youth, reaching 90% of eligible youth graduating while committed to the facility.

FINDING 6 – EVIDENCE IS LACKING TO ENSURE RESIDENTS HAVE CONSISTENT, DAILY ACCESS TO LARGE MUSCLE EXERCISE

Documentation of large muscle exercise in logbooks is inconsistent. As a result, it is difficult to confirm the exercise was provided. Logbook entries reviewed did not evidence that residents had consistent, daily access to large muscle exercise. Auditors obtained three monthly logbooks for four units and reviewed thirty days for each unit. Logbooks are updated by housing unit staff during performance of their normal duties. The following exceptions were noted:

- 22 of 30 (73%) days for one unit did not have large muscle exercise documented
- 26 of 30 (87%) days for one unit did not have large muscle exercise documented
- 20 of 24 (83%) days for one unit did not have large muscle exercise documented (six of the 30 sampled days were missing from the logbook)
- 24 of 30 (80%) days for one unit did not have large muscle exercise documented

Basketball Court in a Courtyard

Virginia Administrative Code 6VAC35-71-660 states that: "A. Each JCC shall implement a recreational program plan that includes: 1. Opportunities for individual and group activities; 2. Opportunity for large muscle exercise daily;…" Additionally, DJJ VOL IV - 4.1- 2.06: Logbooks states that housing unit staff shall include 18 entry types including "housing unit recreation and large muscle activity, including reasons not completed."

DJJ management agreed that large muscle exercise was not consistently documented but was confident it was offered. Unit schedules are not consistently used and/or updated so it is difficult

to compare logbook entries to a schedule of activities for the day. Without proper documentation or consistent access to large muscle exercise, DJJ cannot ensure the physical needs of residents are being met.

Recommendations:

1. Ensure large muscle exercise is provided to residents as required and that this exercise is adequately and accurately documented.
2. Determine if manual documentation of large muscle exercise is an effective, efficient method of documentation. If so, they should:
    a) Review and revise the policy on logbooks to ensure that all required entries are necessary and feasible.
    b) Ensure that staff are trained in what should be documented.
    c) Ensure there is sufficient staffing to maintain accurate logbooks.
    d) Ensure that logbooks are reliable.
    e) Ensure that the paper documentation is consistently completed by all staff and units.
3. Identify a better process (including potential digital systems) for documenting large muscle exercise, if it is determined that the manual documentation process is not effective.

DJJ Management's Response:

Management agreed with the observation, disagreed with the finding, and agreed with the recommendations as follows:

While the Department's logbook procedure (VOL IV 4.1-2.06) lists Large Muscle Activity as one of the activities to document, the JCC regulation focuses on implementation of the recreation plan, to include the opportunity for Large Muscle Activity. Procedures can be waived due to evolutions in practice, regulations cannot. Residents have the opportunity for Large Muscle Activity during the time whenever a youth is out of their room "on the floor". As that happens for substantial periods of time throughout the day, the documentation of the activity does not occur during these times. Additionally, scheduled recreational activities occur three times a week with the recreation specialists and daily on the unit. The Department's current practice is to specifically document large muscle activity only during the time periods in which a youth is on a room confinement. There is no indication of room confinement status in the observation, and therefore the documentation reviewed was covering youth that were out of their rooms, with the opportunity to participate in large muscle activity. Therefore, we agree with the observation but not the finding and appreciate the observation that the logbook practice does not match the procedure. We do agree to improve documentation of Large Muscle Activity for all youth, not just the youth on room confinement.

FINDING 7 – THE WELL BEING OF RESIDENTS IN SPECIAL HOUSING COULD NOT BE VERIFIED DUE TO DEFICIENCIES IN PROCEDURE UPDATES, DOCUMENTATION, AND MONITORING

The Resident Discipline Procedure (VOL IV-4.1.1.16) provides uniform resident accountability procedures and ensures procedural due process safeguards to protect residents' rights in behavior management matters. Minor disruptive and non-compliant behavior is addressed through an informal process utilizing verbal redirection and other redirection strategies in accordance with the facility behavior management program. Behavior that rises to the level of chargeable offenses (such as escape, AWOL, sexual abuse, possession of high security contraband, attempted escape, assault on resident or non-resident, fighting and sexual misconduct) or other serious behavior must be reported on a Disciplinary Report. From review of the Disciplinary Report and investigation (if warranted) a determination of the next steps is made. As part of the determination, a decision is made whether the resident shall be placed in Pre-Hearing Detention, and if found guilty of a chargeable offense, whether other sanctions that result in special housing (disciplinary segregation) will occur. Additionally, the Resident Discipline Procedure follows Virgina Administrative Code 6VAC35-71-1110. Disciplinary process.

The Special Housing Procedure (VOL IV 4.1.2.28) establishes standard procedures for referral, placement, and treatment of residents temporarily assigned to special housing status which is temporary placement of a resident in their designated room on their unit and are placed in a temporary segregated status (i.e. Special Housing Status). Residents may be temporarily placed in special housing in order to maintain the safety and security of the resident, other residents, or staff or to maintain the security or orderly running of Bon Air. According to the procedure, the following placements are considered special housing:

- Pre-Hearing Detention.
- Disciplinary Segregation.
- Administrative Hold.
- Investigative Hold.
- Protective Custody.
- Intensive Behavior Redirection Unit.

According to Virginia Administrative Code 6VAC35-71-1140. Room confinement: "Whenever a resident is confined to a locked room, including but not limited to being placed in isolation, staff shall check the resident visually at least every 30 minutes and more frequently if indicated by the circumstances." Moreover, Department of Juvenile Justice (DJJ) procedure *VOL IV-4.1-2.04 Movement and Supervision of Residents 4-19-2018* section 2.04-4.1 – Supervision of Residents indicates that at no time should more than 15 minutes lapse between periods when residents are observed.

The following were OSIG's testing observations of 29 residents, including six Administrative Holds, 19 Disciplinary Segregation, and four Pre-Hearing Detentions, that were identified in the implementation and documentation of special housing placements as a result of resident discipline:

- Outdated Standard Operating Procedures – Special Housing procedure (VOL IV-4.1-2.28), effective April 14, 2014, has not been updated to reflect procedural changes outlined in standard operating procedure bulletins #2023-03 (Special Housing Placement Reviews) and #2024-09 (Pre-Hearing Detention).
- Typed Signatures were in lieu of Handwritten Approvals and Attestation for the following
    - Five of six (83%) Administrative Hold confinement approval forms used typed signatures instead of handwritten ones.
    - Two of six (33%) Administrative Hold confinement approval forms used typed signatures to attest that residents received notice and had the opportunity to request assistance and/or witness for the Institutional Classification and Review Committee hearing.
- For one of six (16%) Administrative Hold confinement approval forms, the resident review section of the form was not completed.
- Three of six (50%) Administrative Hold placements had gaps/lapses in the 15-minute visual resident checks noted on confinement monitoring forms.
- For six of six (100%) Administrative Holds reviewed, confinement monitoring forms did not indicate that each resident had been visited by health services staff within 24 hours of special housing placement.
- Four of 19 (21%) Disciplinary Segregation placements reviewed did not have confinement approval forms.

While the cause(s) for the deficiencies noted related to special housing placement have not been clearly identified, those that are described indicate inconsistent adherence and application of documentation standards, insufficient oversight of confinement monitoring and logbook practices, and lack of comprehensive and timely procedural updates.

With these noted deficiencies, there is the inability for DJJ management to verify the safety and well-being of residents placed in special housing as well as the potential for violations of resident rights.

Recommendations:

1. Special Housing standard operating procedures should be updated to incorporate and reflect all relevant bulletins and procedural changes.
2. Management should ensure special housing procedures and protocol are followed including:

   a. Handwritten signature approvals on forms,
   b. Completion of all applicable document sections, and
   c. Resident room checks in 15-minute intervals.
3. Management should conduct training as needed and perform quality assurance reviews to verify the completeness and legibility of logbook entries and confinement monitoring forms. Results of quality assurance reviews should be reported to DJJ leadership.
4. Management should require and retain all confinement approval forms for all special housing placements in accordance with agency retention policies.

DJJ Management's Response:

Management conditionally agreed with the observation but did not agree with recommendation 2a as follows:

Recommendation 2(a) suggests that we require handwritten signature approvals on forms but not all of the approval sections require signatures by procedure. Since these forms are frequently completed at odd hours or need approval from someone who is not on-site for other reasons, it would hinder the process to require handwritten signatures.

Special Housing Procedure (VOL IV-4.1-2.28) has been in the most current revision process since May 2025 and has now been finalized with an effective date of December 1, 2025, and a new title: Room Confinement (VOL IV 4.1-2.28).

Neither the old procedure nor form required a signature; only the name of the administrator granting approvals, which is why 5 out of 6 forms had typed names as the requester. The form does include a section that requires signatures of a staff member and the resident and in that section of the form the signature line is clearly labeled, consistent with the wording of the procedure.

The Department has historically struggled with the technological and fiscal constraints limiting the ability to move written documentation processes to a more efficient and reliable technology-based applications. The Department agrees that the facility age, condition, functional ability and resources granted to the Department remain the largest challenges to all service delivery. Over the past four years, monumental efforts have occurred to address vacancy rates, improved services and programming for youth with the means granted to us. Previous closures of Juvenile Correctional enters with no replacement has resulted in the department being limited to an aging facility not conducive for rehabilitative services. The Department has prioritized service delivery and as such, documentation remains a struggle.

FINDING 8 - DOCUMENTATION OF INCIDENTS AND GRIEVANCES NEEDS TO BE IMPROVED

The Department of Juvenile Justice (DJJ) has implemented processes and procedures to manage the reporting and addressing of incidents, and the process of how resident grievances are managed and processed within Bon Air. The purpose of incident reporting is to ensure that all events which threaten the safety, security, or well-being of residents, staff, or Bon Air are accurately documented, investigated, and addressed in a timely manner. In addition to the incident reporting, the grievance process provides both residents and staff with a safe, confidential, and structured method to raise concerns, complaints, or allegations regarding their treatment, living conditions, or the conduct of others. Grievance forms are made available across Bon Air, including in each housing unit (HU) for residents and staff. BADGE (Balanced Approach Data Gathering Environment) is DJJ's electronic data management system. It contains searchable resident data and hosts multiple modules for data entry and reporting, including the "Incident Reporting" module where serious incidents are input from paper forms.

DJJ's process for addressing and documenting incidents and grievances is not operating in accordance with DJJ policy. The process is highly manual and relies on staff to fill out paper Institutional Incident Reports (IIRs) and Grievance forms while also performing their other duties. As a result, paper forms often lack required information. Testwork identified discrepancies related to the timeliness of reporting on incidents and grievances, and completion of documentation non-critical and serious incident reports and grievance forms. OSIG reviewed incidents and grievances to ensure that they were in compliance with Virginia Administrative Code 6VAC35-71-60 (regarding serious incident reports), Virginia Administrative Code 6VAC35-71-80 (regarding grievance procedures/processes), DJJ VOL IV-4.1-1.01 Incident Reports Procedure, and VOL IV-4.1-1.15 Resident Grievances and Complaints Procedure. The criteria that is captured within the Virginia Administration Code and DJJ procedures for both incidents and grievances includes the following, but is not limited to, ensuring timelines of reporting and response, the appropriate reviews have been captured, reporting to the correct level of command, the appropriate documentation is captured, the appropriate classification of the type of incident or grievance is captured, etc. OSIG sampled 25 grievances, 50 non-critical incidents, and 14 serious incidents. The following discrepancies were identified:

- 24 of 89 grievance and IIR forms were not signed and/or dated by the appropriate staff member and/or reviewer, as follows:
    - 16 of 50 (32%) IIRs related to non-critical incidents,
    - 2 of 14 (14%) IIRs related to serious incidents, and
    - 6 of 25 (24%) grievance forms.
- 29 of 50 (58%) IIRs related to non-critical incidents did not include the incident type.
- 2 of 50 (4%) IIRs related to non-critical incidents did not include the name of the person who completed the report.

- 6 of 50 (12%) IIRs related to non-critical incidents and two of 14 (14%) IIRs related to serious incidents did not identify the action taken as a result of the report.
- 9 of 25 (36%) grievances forms were not signed and/or dated by the residents.
- 3 of 25 (12%) grievance forms the Human Rights Coordinator (HRC) did not document the final determination.
- 1 of 7 (14%) non-emergency grievance forms (25 grievances were tested in total with 7 of the grievances being classified as a non-emergency grievances) was not signed and/or dated by the investigating staff.

OSIG also identified discrepancies related to incidents and grievances not being reported timely.

- 6 of 50 (12%) IIRs related to non-critical incidents were not completed by the staff member within four hours of the incident and/or not reported to shift command timely.
- 12 of 25 (48%) emergency grievances were not addressed by staff timely and/or signed and dated to evidence that the emergency grievance was addressed.
- 9 of 25 (36%) grievance forms were not signed and dated by the HRC within five business days or did not document when the grievance was received.

Manual processes are duplicated when information is entered into the BADGE system by supervisors, which negatively impacts efficiency and leads to required information being left out of BADGE.

- 1 of 14 (7%) serious incidents did not indicate the juveniles involved in the incident documented in BADGE.
- 3 of 14 (21%) serious incidents did not indicate the staff involved in the incident documented in BADGE.

In all, OSIG identified exceptions for 40 of the 50 (80%) non-critical incidents, 8 of the 14 (57%) serious incidents, and 19 of the 25 (76%) grievances tested.

Additionally, DJJ's BADGE system lacks key features such as notification tracking and approval logging. Currently BADGE does not log if/when notifications are emailed to required parties such as the DJJ Director. The Director was able to provide proof of notification for seven of the 14 (50%) serious incidents reviewed. Lastly, the "lock/unlock" feature (previously used to "close" incidents) is no longer used. As a result, all incidents documented in BADGE appear to be "open" when the matter has in fact been addressed.

Virginia Administrative Code 6VAC35-71-60 – regarding serious incident reports, sets specific requirements of Juvenile Correction Facilities for responding, investigating and reporting out on the results. This includes the requirement that specific events shall be reported as soon as practicable, but no later than 24 hours after the incident. DJJ leadership has developed procedures for the notification and documentation of incidents and all associated events, which

are outlined in DJJ Policy 1.01-4.11.01. The procedure was created in order to develop processes related to incidents that are in line with Virginia Administrative Code 6VAC35-71-60.

Virginia Administrative Code 6VAC35-71-80 - regarding grievance procedures/processes, sets specific requirements of Juvenile Correction Facilities for responding, investigating and reporting out on the results. DJJ leadership has developed procedures (DJJ Procedure IV-4.1-1.15) to outline the process for hearing and resolving the complaints and grievances of committed residents. The procedure was created in order to develop processes related to grievances that are in line with Virginia Administrative Code 6VAC35-71-80.

Without complete and accurate documentation, DJJ cannot evidence that incidents and grievances are addressed completely or timely. Untimely reporting and documentation of incidents and grievances can jeopardize resident and staff safety.

Recommendations:

1. Ensure that current processes and documents are implemented in a manner that captures all required information and addresses issues timely, including:
    a. Forms are signed and dated by the appropriate staff member and/or reviewer.
    b. Incidents include the type of incident.
    c. Actions taken are documented.
    d. Residents are signing the forms.
    e. The final determinations are documented by the HRC.
2. Work to identify potential automation of the processes to reduce administrative burden and lessen the potential for errors in documentation and untimely actions.
3. Ensure that a quality assurance process is implemented to review a sample of grievances and incidents to ensure that the process is working as intended and that issues are properly addressed. These results should be reported to DJJ leadership.

DJJ Management's Response:

Management agreed with the observation and the recommendations as follows:

Over the past four years, monumental efforts have occurred to address deficiencies in the documentation processes. The Department has historically struggled with the technological and fiscal constraints limiting the ability to move written documentation processes to a more efficient and reliable technology-based applications. To address this struggle, we have implemented carbon copy grievance forms to assist the youth in tracking their grievances, as well as incorporated training into the field training discussion and increased staff coaching. We have monthly meetings with the disability law clinic to ensure increased response and communication in addressing resident concerns. Previous closures of Juvenile Correctional enters with no replacement has

resulted in the department being limited to an aging facility not conducive for rehabilitative services. The Department has prioritized service delivery within the resources granted to it, and as such, documentation remains a struggle.

On October 7th and 20th, 2025, DJJ's Resident Rights Legal Support Manager provided intensive in-person training to the HRC team regarding the procedural requirements contained in Resident Grievances and Complaints (VOL IV-4.11-1.15), to include a review of OSIG's audit findings.

DJJ has been waiting for the fiber project completion to begin the process of procuring digital platforms for many of our documentation processes. Without the completion of the fiber project, which took approximately four years, the necessary technology could not be supported throughout the JCC. With the fiber project recently completed, DJJ has been exploring the feasibility and cost of digital platforms for record keeping in a variety of areas. While DJJ intends to procure software to improve the reliability of the records in this and other areas, the process can take months or years, especially when resident personal identifying information may be involved as the security requirements increase. DJJ will need additional resources to implement the more ambitious goals of this and other corrective actions.

FINDING 9 – RESOLUTION OF RESIDENT CONCERNS WERE NOT ADEQUATELY DOCUMENTED

Bon Air demonstrates a strong commitment to resident engagement through well attended monthly Resident Advisory Council (RAC) meetings. Attribute testing of meeting attendance sheets from April 2025 to July 2025 confirmed consistent participation by resident representatives from most housing units and key senior staff, supporting the inclusiveness and integrity of the process, and ensuring compliance with Virginia Administrative Code 6VAC35-71-90: Resident advisory committee.

According to the Department of Juvenile Justice, Division of Residential Services, Standard Operating Procedure *VOL IV - 4.1-4.07 Resident Council*, the RAC is intended to provide residents with "the opportunity to have input into planning, problem-solving, and decision-making in areas of the residential program that affect their lives." While RAC meetings are not the primary channel for addressing urgent or high-risk individual needs, which are handled through other established avenues, the council serves an important role in promoting resident voice and collaborative problem-solving in day-to-day program matters.

Review of RAC minutes for monthly meetings held between April 2025 and July 2025 revealed documentation and follow-up practices require improvement. Most concerns raised during the review period lacked clear follow-up or resolution. Of the 22 concerns identified:

- Two concerns included documentation clearly indicating resolution.
- Ten had some discussion or reference to the concern; however, there was insufficient evidence to determine follow-up occurred or resolution was achieved.
- Three specifically included mentions of follow-up, but only one had documentation of follow-up. Even in that one case, the final outcome was unclear.
- Seven concerns had no evidence of follow-up or resolution.

One of the unresolved concerns raised in May 2025 involved a resident awaiting glasses. While the issue appeared to be partially addressed during the meeting, there was no formal follow-up or confirmation that glasses were ultimately received.

Documentation should be clear, complete, and structured in a way that facilitates transparency, accountability, and auditability. This includes maintaining records that clearly identify the concern, responsible parties, action steps, and resolution status to ensure timely and appropriate responses.

Bon Air has not implemented standardized procedures for documenting and tracking resident concerns raised during RAC meetings. The absence of a centralized tracking mechanism and a

structured meeting minute template contributes to inconsistent documentation and limited follow-up.

Without a standardized and centralized approach, it is difficult for DJJ management to know whether resident concerns are resolved in a timely and transparent manner. This increases the risk that some issues may go unaddressed, reducing accountability, impairing the value of RAC meetings, and potentially eroding resident trust in the process.

Recommendations:

1. Implement a standardized meeting minute template that includes clearly labeled sections for resident concerns, responsible staff, action steps, and resolution status.
2. Develop and maintain a centralized tracking log of all resident concerns raised during RAC meetings, updated regularly to reflect follow-up actions and outcomes.
3. Ensure that meeting minutes explicitly state when no concerns are raised to avoid ambiguity.
4. Apply consistent formatting and categorization of concerns across all meeting records to support effective tracking and analysis.

DJJ Management's Response:

Management agreed with the observation and the recommendations as follows:

Some of the concerns raised during Resident Advisory Council are specific to individual residents and the issues need to be addressed on an individual level. Some concerns may not have a feasible resolution in the control of the JCC or agency so having a platform for the residents to voice these concerns is the best remedy we can provide.

The Department appreciates the observation of the review team of the Departments' strong commitment to supporting the residents in our care. The resident well-being remains the largest focus of the Department and the Administration. Previous closures of juvenile correctional centers with no replacement has resulted in the Department being limited to an aging facility not conducive for rehabilitative services. The Department has prioritized service delivery within the resources granted to it, and as such, documentation remains a struggle. However, we are proud that despite the continued challenges the facility faces, we are able to regularly provide this meaningful resident engagement process.

FINDING 10 - RESIDENT GOOD BEHAVIOR POINTS CAN'T BE VERIFIED

Residents can earn points for exhibiting good behavior, to include keeping their rooms clean, attending school and group activities, and overall, not causing any problems while on the unit. Points earned by residents allow them to purchase special hygiene products, snacks, additional phone calls, and participate in special events. The residents can earn a maximum of 162 points a day. These are paper points cards that are kept that the resident takes with them throughout the day and the Teachers and JCS staff must initial the card and circle the points earned. Once a week the residents receive a "menu" which lists all the things they can use their points toward (additional hygiene products, snacks, additional phone calls, and special events), the point cost for each menu item, and their current point balance. Points are rewarded and accumulated for good behavior. Residents can also lose between 500 and 1,500 points for chargeable offenses, depending on the seriousness, ranging from abusive language to assaults on residents and staff.

Resident point balances are maintained by the Behavior Analytic Team in an excel spreadsheet, but the spreadsheet is maintained in a way that individual point activity is difficult to trace to supporting documentation. In addition, the units were not turning in point cards for each resident. The Facility Wide-Positive Behavioral Interventions and Support (FW-PBIS) Manual dated April 1, 2024, also states: "Physical point cards are retained for 3 months…. Daily point card values are entered into the PBIS point tracker by the designated member of the Behavior Analytic Team." At the time of the audit, three months of point cards were not available, so 16 days in July and all of August 2025 (for a total of 47 days) for 16 residents were reviewed. Of the 752 individual total possible point cards, 77 (10%) cards were not available.

Facility Wide-Positive Behavioral Interventions and Support (FW-PBIS) Manual dated April 1, 2024, states: "…If a resident loses or fails to produce their card at the end of the day, staff should write "No Card Submitted" on a new replacement point card that will be submitted for documentation purposes and the resident will receive zero (0) points for the entire day… If it is determined that a staff member intentionally destroyed, traded, or purposefully lost/threw away a resident's card, progressive discipline will be applied for the staff and the resident will receive a new point card with maximum points up to the time the replacement is issued." In addition, points are the only way residents have to purchase menu items and they should be accurate and easily recalculated, to include points earned, points lost, and points spent on purchases.

The Behavior Analytic Team provides point balances to residents weekly so if there were any questions only the weekly point activity would need to be reviewed. There was no clear way to determine daily activity from the spreadsheets if a resident questions their balance. DJJ management may not be able to support the balances by reviewing supporting documentation if the questions were escalated. Further, if the daily point cards are not collected for each resident,

there is no way to conclude whether a resident's card was misplaced, or the point card was not turned in by the unit due to no points awarded.

Recommendations:

1. Ensure that the spreadsheets maintained for the points earned by residents contain enough detail so that the amounts can be traced back to supporting documentation.
2. Ensure that points cards are turned in daily for every resident no matter how many points are earned.
3. Ensure that point cards are maintained for at least 90 days in accordance with the FW-PBIS Manual.
4. Develop a process to spot check and reconcile point cards on a cyclical basis to ensure that point balances are properly maintained.

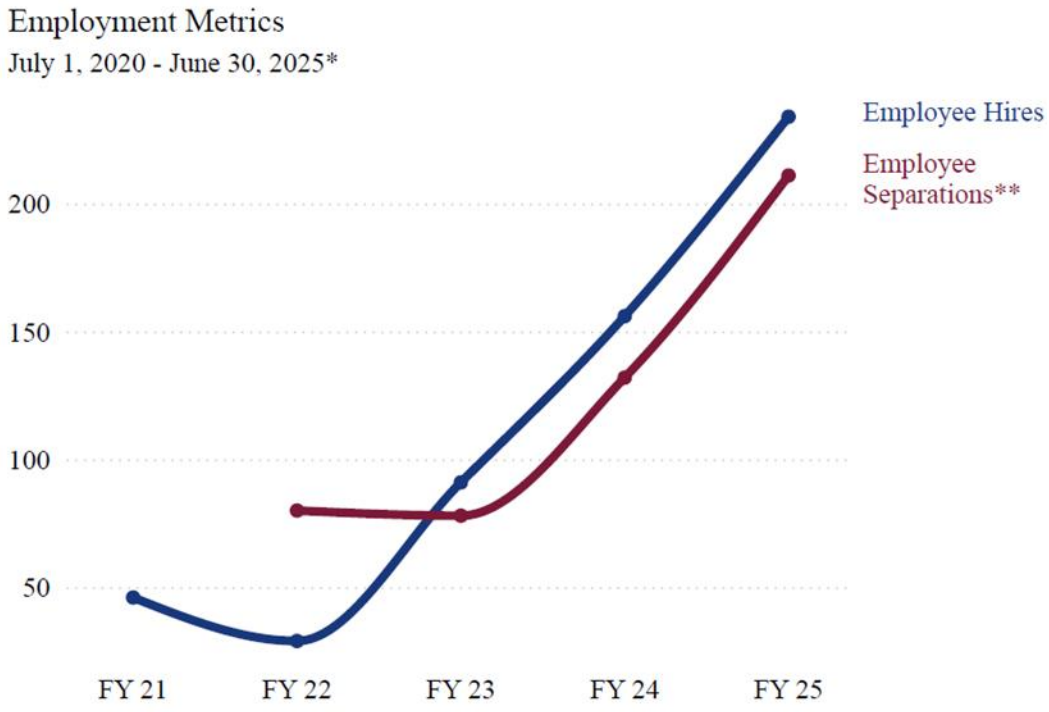
DJJ Management's Response:

Management conditionally agreed with the observation and agreed with the recommendations as follows:

PBIS has an expected implementation timeline of 3 years for Tier 1 supports. We began implementation on April 1, 2024, and therefore implementation to fidelity is ongoing. As we did not expect perfection at this point in the implementation timeline, we appreciate the assistance of OSIG in helping us to identify areas where attention is needed. Research suggests that Tier 1 supports will eventually work for 80% of youth. Less than halfway through DJJ's implementation timeline we are already seeing success with 66% of our population and expect to continue to improve steadily until reaching or exceeding the 80% mark. We are proud to be ahead of the timeline and the positive response from youth participation and are excited to continue proceeding to full implementation. We appreciate the acknowledgement and support of the OSIG team throughout the implementation of this positive and data-supported behavioral management program. We expect continuous improvement on these concerns as the implementation process continues along the associated timeline.

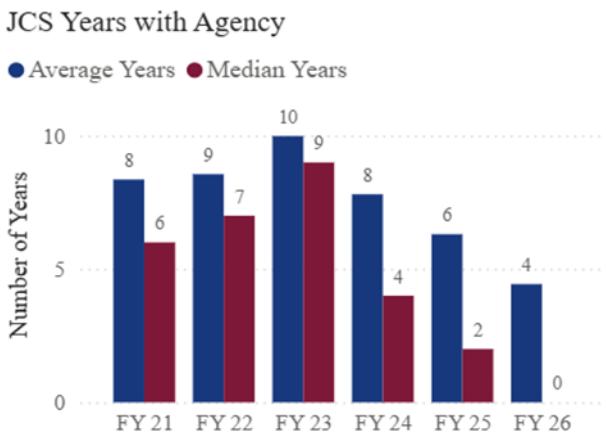
FINDING 11 - HIGH TURNOVER AND SHORT TENURE OF BON AIR STAFF UNDERMINE WORKFORCE STABILITY AND SERVICE DELIVERY

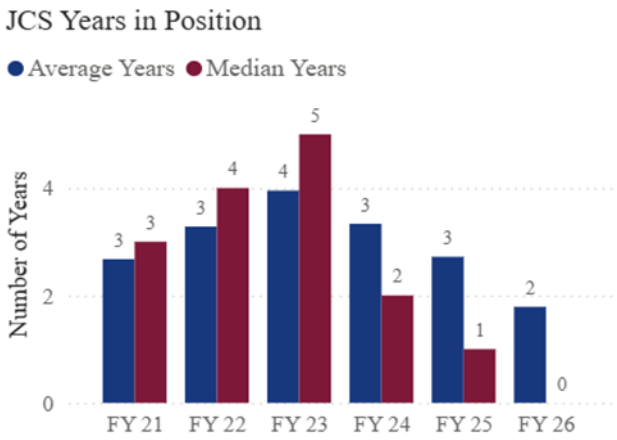
OSIG conducted a comprehensive analysis of DJJ workforce trends for the period of July 1, 2020, to August 1, 2025. This included a review of hiring and separations, employee tenure, and compensation data. OSIG found that DJJ experienced a significant increase in both hiring and separations, particularly since FY22.



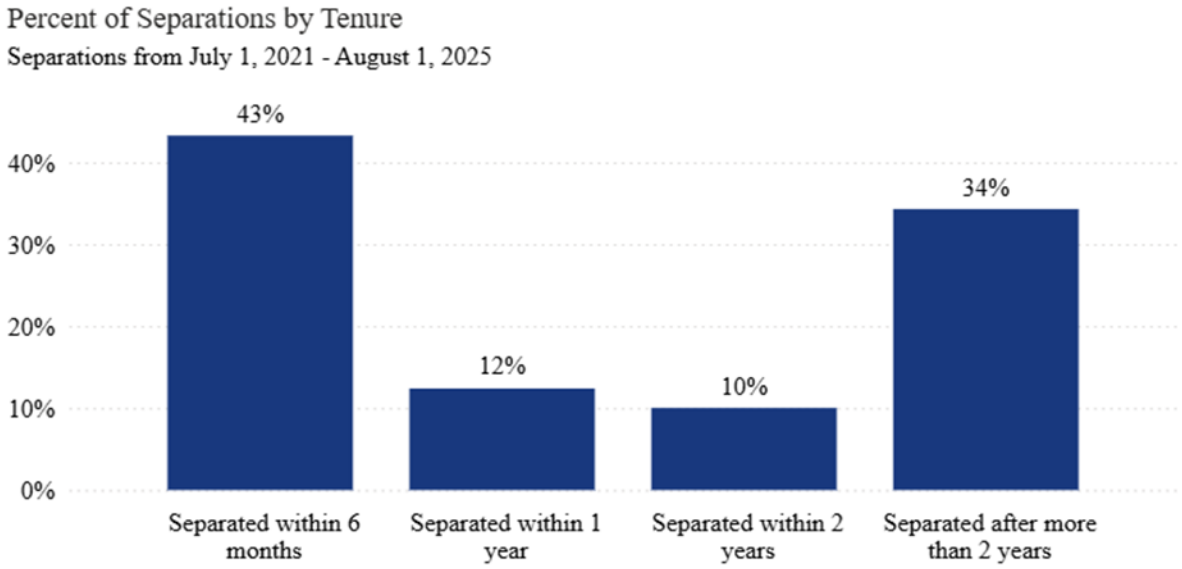
*Data from July 1, 2025 - August 1, 2025 is not included in the graph because it does not reflect an entire fiscal year.
** Separations include both voluntary and involuntary separations based on employee's Terminated Date in Cardinal.

Employee tenure has also declined, especially among Juvenile Correctional Specialists (JCS). Since FY23, the median years of service for these roles have halved annually. As of August 2025, at least half of JCS staff classifications of Security Officer III and IV had less than one year of tenure.



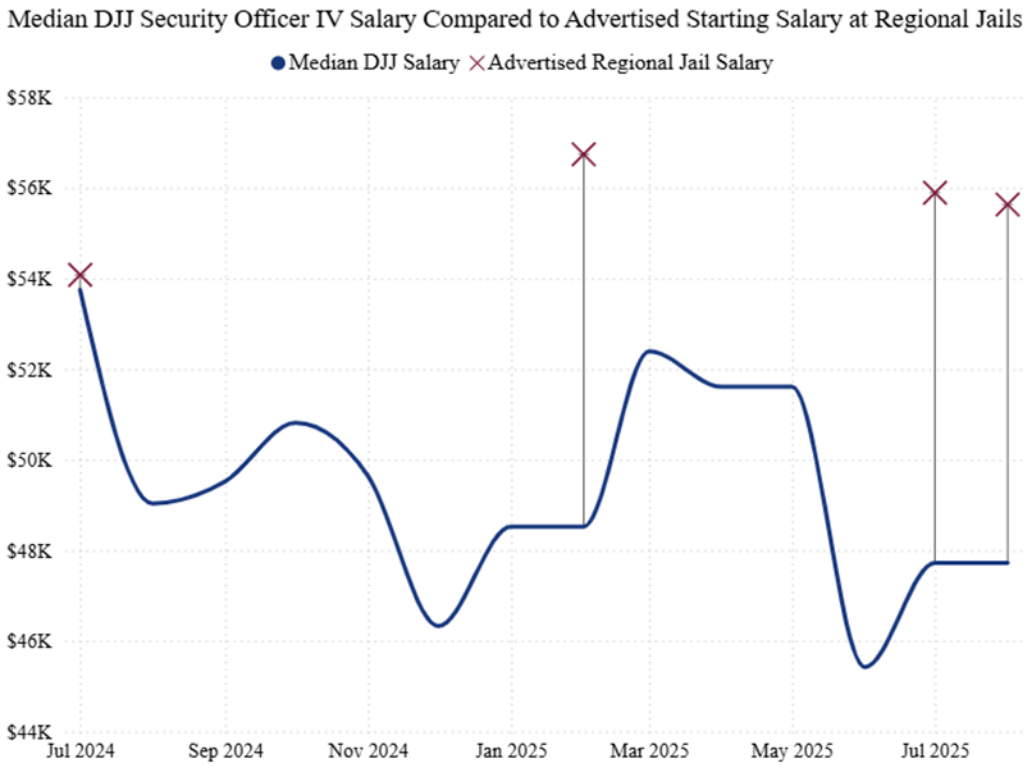


In addition, a turnover analysis of classified employees was conducted using available DJJ data from July 1, 2021, through August 1, 2024, for the following departments: Miller School Bon Air Campus (50001), Bon Air Juvenile Correctional Center (50712), Medical Services (50750), and Psychological Services (50755). This analysis showed that more than half (56%) of all separations occurred within the first two years of employment, with nearly 43% occurring within the first six months. Security Officer III and IV classifications accounted for the largest share of these early separations.



A compensation analysis, using data from July 1, 2020, to August 1, 2025, revealed inconsistencies across classifications and agencies. DJJ Security Officer IVs earn less than that of similar positions with Virginia Department of Corrections (VADOC), while DJJ Security Officer IIIs at the 25th percentile earn more than 75% of VADOC employees in the same role. Overtime compensation was modest, with most Security Officers receiving less than 80 hours per month and median overtime for Security Officer IIIs remaining under 40 hours per month,

except for three outlier months. City and county jails located within the Richmond metropolitan region also offer higher starting salaries than DJJ's median pay for Security Officer IVs.



Lower salaries create the risk that DJJ is training staff to lose them to higher paying roles in other agencies.

JCS' operate under a developmentally focused correctional model that requires continuous engagement with youth, de-escalation without chemical agents or weapons, and support for rehabilitative programming. Effective workforce management practices emphasize employee retention, adequate compensation, and job alignment to ensure continuity of operations,

institutional knowledge retention, and service quality. The Department of Human Resource Management (DHRM) also encourages agencies to monitor turnover trends and develop strategies to address recruitment and retention challenges, including the risk that DJJ is training staff only to lose them to higher paying roles.

Several systemic and structural factors contribute to these workforce challenges:

- DJJ has limited control over salary structures and job classifications, which are governed by statewide policies.
- The JCS role is uniquely demanding, requiring specialized skills and emotional labor.
- Despite increased recruitment efforts, retention strategies, including the use of sign-on and retention bonuses, have not fully addressed the underlying causes of early separations.

High turnover and short tenure among JCS' impact DJJ's ability to maintain a stable, experienced workforce that has experience with the challenges of Bon Air residents. This instability can:

- Disrupt rehabilitative programming and youth engagement.
- Increase training and onboarding costs.
- Reduce institutional knowledge and operational continuity.
- Contribute to staff burnout and morale issues among remaining employees.

Recommendations:

1. Perform or request a classification and compensation review of the Security Officer III and IV roles to help ensure that compensation aligns with similar positions in the industry.
2. Explore targeted retention strategies, such as mentorship programs, early-career support, and other allowable options to help improve retention.
3. Collaborate with DHRM and other stakeholders to identify long-term solutions for workforce stability, including potential legislative or budgetary changes.

DJJ Management's Response:

Management agreed with the observation and the recommendations as follows:

The staffing at Bon Air Juvenile Correctional center has historically struggled, however, we are encouraged that the recent efforts of the Department are showing positive growth, albeit slowly. For example, in FY 2023, the Department reached, and has maintained, a transition point where more staff are being hired than are separating. This is allowing us to grow our numbers slowly. In part, the many challenges facing the department stem from low salaries, and difficult working conditions.

In recent years, we have surveyed staff for concerns, established and created a staff safety advocate, an employee engagement coordinator, executed high value retention agreements, implemented premium and hazardous duty pay. Implemented a therapy dog, and the “you got caught” program for staff morale. To address identified deficiencies, we completed a staffing analysis and created and recruited five separate shifts with associated pay differentials, assigning number and priority based on need. Implemented pay differentials for more unique populations of youth. (ie girls' unit)

Our recruitment team renamed the Residential Specialists positions to Juvenile correctional specialists and clarified the job description to increase recruitment response; implemented hiring bonuses, retention agreements, and expanded advertising to include movie theaters, billboards and radio spots. The team additionally distributed concentrated email blasts for hiring, sought internship opportunities and pathways with community colleges. The Department engaged with the Moss group to do a cultural and physical assessment of the facility and staffing and recruitment issues, developed and implemented Monthly JCS hiring events, and implemented quarterly expanded JCS hiring events in the community. We partnered with Media outlets to facilitate interest and attendance in the events. Recently, in conjunction with the “Keep It 100” recruitment campaign, we collaborated with an external recruitment firm for partnership and consultation.

Additional support and assistance from the General Assembly will be needed to address substantial deficiencies in competitive pay and tools for staff safety.

FINDING 12 - FRAGMENTED HEALTH RECORD SYSTEMS RISK RESIDENT SAFETY AND CONTINUITY OF CARE

Bon Air does not have a comprehensive health records system. Currently, the health records are categorized as either the Behavioral Health Record (BHR) or the resident's general medical record. They are maintained as separate and unintegrated systems, with the Behavioral Services Unit (BSU) managing the BHR, and the Medical Unit overseeing the medical record. To obtain a full picture of a resident's overall health and treatment journey, information must be obtained from several sources including:

- BHR (paper-based).
- Medical record (paper-based).
- BADGE.

Although the BHR is stated to be the behavioral health record, BADGE is the system where individual and group counseling sessions, treatment and case conference meetings, and mental health status checks, amongst other data, are documented. The information documented in BADGE is necessary for treatment and may include entries such as the current state of the patient, symptoms, summary of the theme of the psychotherapy session, diagnoses, medications prescribed, side effects, and any other information necessary for treatment. Currently, documentation practices for the BHR are inconsistent. For instance, required documentation, such as the Treatment Plan and Initial Suicide Risk Assessment, was missing in three BHR records or, in one instance, a different resident's risk assessment was found in the record.

The current health information system's design impairs the ability of providers to deliver cohesive, informed, and timely care which places residents at an elevated risk. Specifically, current Bon Air documentation practices present a risk that the following could occur:

- Incomplete or inaccessible medical and behavioral health histories.
- Delays or errors in treatment due to lack of shared information among providers.
- Compromised clinical decision-making and care coordination.
- Administrative burden and inefficiency.

The lack of integration between clinical data repositories stems from legacy practices separating behavioral and medical health documentation. Since there is no electronic health record (EHR) system, separate record systems are necessary because current users (BSU and Medical) have different levels of access to physical locations within Bon Air. As designed, having only one comprehensive non-electronic health record could significantly impair functionality of both Medical and BSU. Current data repositories are not interoperable.

Industry best practices, including those endorsed by the Virginia Department of Corrections (VADOC), support the use of comprehensive EHRs to improve patient safety, care coordination,

and documentation. The recent statewide implementation of DOCHealth supports these goals by emphasizing:

- Real-time access to complete patient histories.
- Standardized documentation.
- Enhanced coordination between providers.
- Reduced reliance on paper-based systems.

Recommendations:

1. Management should implement an EHR system that consolidates both behavioral and general medical health records into a single, unified platform. This platform should:
    a. Develop and enforce consistent standards for record content, organization, and retention within the system.
    b. Provide comprehensive training to all clinical staff on using the EHR system and maintaining complete, accurate records.
2. Management should determine if it is necessary to continue to use separate paper records for BHR and medical records, and if not, every effort is made by Bon Air to foster access to a single, unified paper health record in a location that is accessible to all healthcare providers.

DJJ Management's Response:

Management agreed with the observation and the recommendations as follows:

While OSIG has identified possible risks of the current records storage system, it is important to note that to DJJ's knowledge, and based on information from OSIG about their field testing, none of the perceived risks have impacted the youth as described and DJJ works diligently to minimize any potential risks through activities such as mock audits and daily huddles between all units on campus.

The Department has historically struggled with the technological and fiscal constraints limiting the ability to move written documentation processes to a more efficient and reliable technology-based applications. The Department agrees that the facility age, condition, functional ability and resources granted to the Department remain the largest challenges to all service delivery. Insufficient resources to attract and maintain staff lead to a high turnover rate, and a higher number of new and learning staff. While we have made numerous efforts to address the challenges, the age of the building, available technology, and fiscal limitations remain outside the control of the Department.

DJJ has been exploring the addition of an EHR system for a number of years but due to limited resources has not been able to procure one. DJJ submitted a budget request for the 2026 General Assembly Session to procure an EHR system.

FINDING 13 - GAPS WERE IDENTIFIED IN EMERGENCY PREPAREDNESS COMPLIANCE AND RECORDKEEPING

DJJ and Bon Air have established comprehensive emergency operations protocols and procedures. A review of available emergency preparedness documentation confirmed that some fire, evacuation, and AWOL drills were conducted across various units and shifts between July 1, 2024, and August 1, 2025. However, some gaps in emergency preparedness documentation and execution were observed:

- No records were provided to show that A Break Night Shift conducted any fire or evacuation drills during the period under review.
- No records were provided to show that any shift conducted AWOL drills during Q1 or Q2 of FY2025. Only B Break Day Shift was documented as having conducted AWOL drills for Q3 of FY2025. However, their corresponding drill documentation showed four of 11 posts lacked staff assignments and radio checks with Central Control, with no explanation provided for the omissions. This is inconsistent with DJJ's Emergency Response Plans SOP, which requires that each post be assigned and that staff notify the shift commander upon reaching their assigned post.
- No records were provided for mass disaster or juvenile-down medical emergency drills.
- No records were provided to show that tabletop exercises were conducted for active shooter, pandemic, natural disaster, or campus-wide evacuation scenarios. Also, there was no evidence that Bon Air conducted the required annual exercise outlined in their Emergency Operations Plan (EOP), in which leadership must contact VITA for record backups, as specified in the Records Request section.

Additionally, while emergencies occurred during the audit period, OSIG was unable to assess whether these incidents were recorded or reported, as DJJ did not provide the requested documentation. As a result, OSIG could not determine whether appropriate follow-up actions, such as post-incident debriefs, corrective measures, or evaluations of resident impact, were conducted

In accordance with 6VAC35-71-460, Bon Air's emergency preparedness activities are governed by DJJ's Standard Operating Procedures (SOPs) and Bon Air's Emergency Operations Plan (EOP). *DJJ SOP VOL IV – 4.1-2.09 Emergency Response Plans* states that shift commanders are required to conduct quarterly escape or AWOL drills across day, evening, and weekend shifts, with documentation maintained on Shift Status Reports. The same SOP mandates that each building occupied by residents must conduct at least one fire drill per month. Additionally, each shift must conduct at least one evacuation drill within any three consecutive calendar months to ensure comprehensive coverage.

Medical emergency preparedness is addressed in *DJJ SOP VOL IV – 4.3-4.09 Medical Emergency Response Plan*, which requires the Local Health Authority to coordinate with the Bon Air superintendent to ensure health services staff participate in all emergency drills. This includes conducting and critiquing at least one mass disaster drill and one juvenile-down drill annually, with the latter covering all shifts.

In addition to these operational drills, the *Bon Air Juvenile Correctional Center Emergency Operations Plan (2021)* outlines requirements for annual tabletop exercises simulating critical scenarios. These include active shooter incidents, pandemics or infectious disease outbreaks (on a rotating annual basis), large-scale natural disasters, and campus-wide evacuations, the latter of which must be conducted quarterly.

Finally, both the Emergency Response Plans SOP and the Bon Air Emergency Operations Plan (EOP) require that an After-Action Review (AAR) be completed following each drill, exercise, or actual emergency event. The Bon Air EOP further requires the development of an accompanying Improvement Plan (IP) to formally address findings and enhance future preparedness. These reviews must identify areas for improvement, incorporate staff feedback, and propose corrective actions. The AAR must be reviewed and approved by the agency head and submitted to the Deputy Director for Residential Services, with lessons learned integrated into future planning.

The absence of documentation for fire, evacuation, AWOL, or juvenile-down medical emergency drills, tabletop exercises, and AARs between July 1, 2024, and August 1, 2025, indicates that required drills and exercises were not conducted. It could also indicate that Bon Air's recordkeeping practices are insufficient.

The lack of documented evidence for several critical drills, exercises, and related post-incident evaluations limits assurance that DJJ and Bon Air are fully complying with established emergency preparedness requirements and protocols and increases the risk that staff and residents may not be adequately prepared for certain emergency scenarios. In the event of an actual emergency, such as a fire, medical crisis, or security threat, this lack of preparedness could result in delayed response times, confusion among staff, and increased risk of harm to residents and personnel. It also represents a missed opportunity to learn from real incidents and improve future responses.

Recommendations:

1. Implement a centralized tracking system to ensure all required emergency drills and tabletop exercises are scheduled, conducted, and documented across all shifts and units.
2. Ensure there is someone responsible for maintaining supporting documentation of drills, tabletop exercises, and actual emergencies.
3. Identify and address any missing or outdated emergency preparedness activities.
4. Ensure a responsible party is assigned to perform a quality assurance review to ensure that documentation of drills, table exercises, and corresponding after action reports are properly performed, maintained, readily available, and results are reported to management.

DJJ Management's Response:

Management agreed with the observation and the recommendations as follows:

The Department has historically struggled with the technological and fiscal constraints limiting the ability to move written documentation processes to a more efficient and reliable technology-based applications.

Despite these limitations, over the past four years, monumental efforts have occurred to address deficiencies in the processes. We implemented a grant to establish an emergency response command center on site. We have conducted tabletop exercise specific to Bon Air and have been having ongoing EOP update meeting son the facility. The Department has also corresponded with the Department of Corrections as to their emergency response procedures and are following up with their recommendations to investigate acquiring additional resources.

FINDING 14 - INTERNAL CONTROLS FOR TIMESHEETS OF OVERTIME AND PREMIUMS WERE LACKING

Salaried Juvenile Corrections Specialist employees complete a 28-day work cycle timesheet that is supposed to be signed by them and their supervisor. All timesheets are collected and submitted by the supervisor to DJJ Central Office Human Resources. Human Resources is responsible for entering the information into Virginia's enterprise resource planning system that integrates financial management, human resources, payroll, health benefits, and other administrative functions for state agencies and localities (Cardinal). Once input to Cardinal, the supervisor is responsible for approving the timesheet. Once approved in Cardinal, the time is included in their pay. Utilizing a sampling tool, a random sample of three work cycles was selected, and from those three work cycles, 25 total employees were selected. The following exceptions were noted:

- Seven of 25 (28%) timesheets selected for review were no longer available for testing.
- Thirteen of 18 (72%) timesheets were not signed by the employee.
- Ten of 18 (56%) timesheets did not match amounts paid in the Cardinal System for overtime and premiums. Out of the 10 timesheets not paid correctly:
    - Six were not paid overtime correctly.
    - Three were not paid premiums correctly.
    - One was not paid overtime and premiums correctly.

Library of Virginia, Records Retention and Disposition Schedule, General Schedule No. GS-102, All State Agencies, Fiscal Records indicates: payroll activities of the agency may include, but is not limited to: deduction authorizations and registers, leave records, ledgers and reports, compensation files, retirement contributions, time and attendance records, and time sheets, should be retained five years after the end of the state fiscal year.

DJJ Management indicated timekeeping concerns have been a long-standing issue. An employee was hired in 2023 to specifically address the timekeeping concerns and enter the time into Cardinal. DJJ has found this to be working well in resolving a good deal of the previous issues. In addition, employees are not always available to sign their timesheets and the supervisor signs without the employee signature so that the employee can get paid timely. Employees are not asked to sign the timesheet after the fact to verify they agreed with the work hours submitted.

Manually entering work cycle information into Cardinal has a potential of input errors. Employees were complaining that they weren't being paid for the overtime and premiums they were owed. In addition, when employees don't sign their time sheets, they don't have a way to ensure the time they worked and are paid is accurate until after payroll has been processed.

Recommendations:

1. Ensure timesheets are retained based on the schedule established by the Library of Virginia.
2. Ensure that employees understand the timing for payment of overtime worked.
3. Ensure employees sign their timesheets, to verify that they agree with the hours worked.

DJJ Management's Response:

Management agreed with the observation and the recommendations as follows:

DJJ has been seeking automation in a number of areas, but to date IT infrastructure was insufficient to support some necessary improvements. With the completion of the fiber project on the Bon Air Campus at the end of this summer, we are now able to move forward with the procurement process for some of the previously identified areas. DJJ has made strides in identifying automated software solutions for many of the paper processes in the agency, as well as earmarked funding for the solutions within our existing operating funds or have already submitted budget requests within the budget development cycle this year. We acknowledge that an all-in-one software solution would be ideal in theory, however, we are also limited on viable systems due to additional protections required by VITA and security standards of PPI data for juvenile records. This may result in multiple system solutions to address specific functions being our most cost-effective and time-consuming approach.

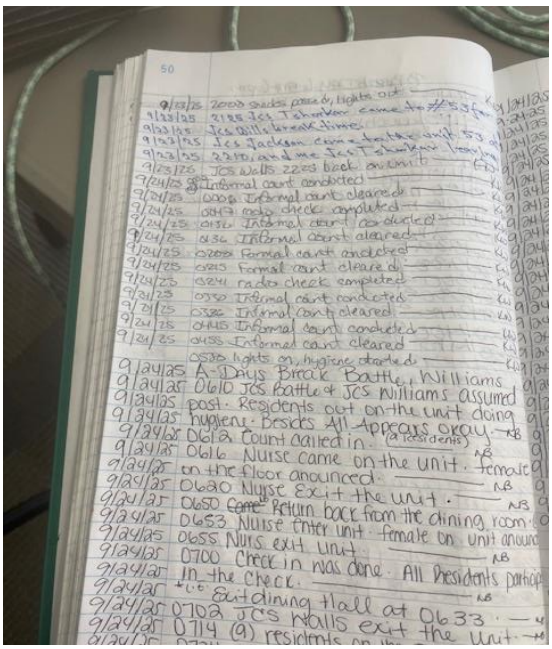
We have begun the process for procuring and implementing an electronic record keeping system and anticipate discussions and requests in the budget development process to support a transition to electronic health records. The Department has historically struggled with the technological and fiscal constraints limiting the ability to move written documentation processes to a more efficient and reliable technology-based applications. The Department agrees that the facility age, condition and functional ability remain one of the largest challenges to service delivery. While we have made numerous efforts to address the challenges, the age of the building, available technology, and fiscal limitations remain outside the control of the Department. Over the past four years, monumental efforts have occurred to address deficiencies in the processes, but we are hindered by the resources provided to us.

FINDING 15 - PAPER RECORDS HINDER OVERSIGHT BY AGENCY LEADERSHIP

Bon Air documents most of their daily activities manually and on paper. Most of the paperwork is placed in bins and not filed or reviewed once the month is over. In addition, not all paperwork is completed the same throughout Bon Air. Although some of the paper may be necessary, there are some opportunities to decrease dependency.

During our audit we were unable to determine populations for sample sizes due to missing records or records lacking detailed information:

- Unit Logbooks – composition books utilized by the Housing Units to record daily resident activity by month.
- Confinement Monitoring Forms – placed on resident unit doors to document visual checks when the resident is behind a secure (i.e. locked) door.
- Grievance Forms – utilized by residents and staff to document grievances they would like to bring to management's attention and resolve.
- Health Records – resident records of all health-related encounters.
- Timesheets – utilized by employees to record time worked and used by DJJ management to key into Cardinal for payment.
- Break Assignment Worksheets – Excel spreadsheet utilized by the Head of Security to document staff assigned to work each break.
- Special Housing Requests:
    - Confinement Approval Forms – utilized to document offenses by residents and disciplinary actions taken. These requests for special housing for residents include pending reviews for protective custody, investigative holds, or administrative holds.
    - Protective Custody Intervention Plans – explains reasons residents are placed in protective custody and expected behaviors and services to receive while in protective custody.
- Point Cards – utilized to document points earned by residents for good behavior daily.



Example of a Logbook

Funding and age of Bon Air are roadblocks to automation, and due to other challenges that had to be resolved, IT advancement has had to take a back seat; however, reliance on hard copy documentation has drawbacks in cost, security, duplication of effort, and accessibility. Utilizing paper documents impacts management's ability to properly manage operations and to evaluate based on actual data. In addition, having so much paper with no one using it, once the month is over, causes extra work for those completing the documents and if needed, employees may spend a lot of time searching for misplaced or lost documents.

Automated systems would allow DJJ leadership the ability to evaluate whether events are occurring as intended at a higher level and throughout Bon Air. It would also allow management to respond to issues quickly, make decisions based on data rather than compiled manual reports, enhance transparency, and help enforce accountability across Bon Air. In addition, automated systems would allow standardization, helping to ensure consistency.

Recommendations:

1. Decide if continuing the manual documentation of processes on paper is the best use of resources. If it is decided to continue the current processes, Bon Air should consider:
    a. Providing summaries of significant events that occurred on the unit for shift change updates rather than logbooks.
    b. Ensuring that paper documentation is consistently completed by all units.
    c. Maintaining the documentation to allow easy accessibility when information about residents are needed.

2. Investigate systems able to alleviate their reliance on documenting processes on paper.
3. Work with the Department of Planning and Budget on a budget request for an automated system to meet the needs of Bon Air. The request should include the cost of implementing the system based on infrastructure and maintaining the system.

DJJ Management's Response:

Management agreed with the observation and the recommendations as follows:

DJJ has been seeking automation in a number of areas, but to date IT infrastructure was insufficient to support some necessary improvements. With the completion of the fiber project on the Bon Air Campus at the end of this summer, we are now able to move forward with the procurement process for some of the previously identified areas. DJJ has made strides in identifying automated software solutions for many of the paper processes in the agency, as well as earmarked funding for the solutions within our existing operating funds or have already submitted budget requests within the budget development cycle this year. However, if the investigation for Corrective Action #2 reveals that additional systems are needed and existing operational funds will not suffice, then DJJ will prepare a budget request for next year's budget development cycle. We acknowledge that an all-in-one software solution would be ideal in theory, however, we are also limited on viable systems due to additional protections required by VITA and security standards of PPI data for juvenile records. This may result in multiple system solutions to address specific functions being our most cost-effective and time-consuming approach.

We have begun the process for procuring and implementing an electronic record keeping system, and anticipate discussions and requests in the budget development process to support a transition to electronic health records. The Department has historically struggled with the technological and fiscal constraints limiting the ability to move written documentation processes to a more efficient and reliable technology-based applications. The Department agrees that the facility age, condition, functional ability and resources granted to the Department remain the largest challenges to all service delivery. Insufficient resources to attract and maintain staff lead to a high turnover rate, and a higher number of new and learning staff. While we have made numerous efforts to address the challenges, the age of the building, available technology, and fiscal limitations remain outside the control of the Department. Over the past four years, monumental efforts have occurred to address deficiencies in the processes, but we are hindered by the resources provided to us.

FINDING 16 – BON AIR LACKS UPDATED PROCEDURES

Multiple areas that are managed within Bon Air do not have procedures that have been updated to reflect the current daily processes that are conducted by staff. We reviewed 72 various procedures in relation to our audit objectives. As part of the review, OSIG found that nine of the 72 procedures have been officially updated by DJJ leadership within the last year. The remaining 63 procedures had not been updated as follows:

- Seven of 72 (10%) hadn't been updated in over one year.
- Four of 72 (6%) hadn't been updated between two and five years.
- Thirty-two of 72 (44%) hadn't been updated between five and 10 years.
- Twenty of 72 (28%) hadn't been updated in over 10 years.

Policies and procedures provide structure and consistency. The American Correctional Association (ACA) Standards for Juvenile Correctional Facilities (5-JCF-7A-17) states: "3. Policies and procedures are reviewed at least annually and updated, as needed." DJJ works to align with the ACA Requirements. DJJ Policy and Procedure 01-002-Developing and Communicating Policies and Procedures states: "The Department shall establish and maintain a Directives Manual which, at a minimum, contains and codifies all approved Board policies, Department procedures, and management orders. This manual shall be available to all employees and shall be reviewed annually and updated as needed."

DJJ management indicated procedures have not been updated due to the lengthy process that is required and changes in management over the past years. Detailed procedures assist employees in successfully carrying out their assignments and help ensure overall conformance to Bon Air operations and standards. The absence of updated procedures makes it difficult for staff to follow a designed process that helps to adequately manage and oversee the operations and functionality of Bon Air. Additionally, not having updated procedures in place:

- Increases the risk of operational inefficiencies regarding the rules, processes, procedures, requirements, approvals, etc. of how activities are to be handled,
- Increases confusion in how operations are to be handled.
- Could hinder uniform treatment, education, and behavioral programming for residents.
- Could expose Bon Air to a higher risk of noncompliance with state juvenile correctional standards and federal juvenile justice regulations.

Recommendations:

1. Update all core operational policies and procedures prioritizing those impacting safety, security, and compliance.
2. Ensure annual reviews, approvals, and documentation of all procedures is occurring.
3. Ensure staff are updated when there are procedure changes that impact their job duties.

4. Consider implementing a centralized digital policy management system with version control, change tracking, and automatic review reminders.

DJJ Management's Response:

Management agreed with the observation and the recommendations as follows:

Procedures are utilized by the Department, and referred to by senior leadership, on a regular basis. As such, many are, informally, reviewed regularly. It is, in part, through this regular review and use, that prompts management to bring procedures to the procedure committee, regardless of age, for formal review. While the Department recognizes the desirability of reviewing procedures purely due to their age, when Bon Air leadership decides that a procedure must be updated due to changes in process, that procedure goes to the front of the queue, pushing to the back procedures that are just "old." It is not uncommon therefore, for adjustments in an actual facility practice to occur prior to the associated procedure being updated, creating a variance in the appearance and application of said procedure. Finally, in connection with an audit, *all procedures were reviewed and reissued approximately two years ago*.

We appreciate the thoroughness of the analysis of identified risks. The speculative potential outcomes noted in the end report, especially the last two, are not likely, as previously noted the procedures are utilized on a regular basis, and therefore referred to the procedures committee by management that notes critical changes and updates that need to occur. The Bon Air facility has successfully passed its recent state and federal audits.

FINDING 17 - BREAK ASSIGNMENT WORKSHEETS TO ASSIST WITH ADEQUATE STAFFING LEVELS ARE NOT MAINTAINED

Bon Air does not retain documentation of past staff assignments and schedules. As a result, management cannot confirm there was sufficient staff to maintain operations prior to the current operating environment. Bon Air maintains an Excel worksheet for security staff and Housing Unit Coordinators, which is managed by the Head of Security. The worksheet is titled BAJCC (Bon Air Juvenile Correctional Center) Break Assignments (BAW) and is used to help ensure there is adequate security coverage throughout Bon Air.

The BAW includes the names of the individuals that will be working on the designated shifts. Security staff and Housing Unit Coordinators at Bon Air have Break A, Break B, and Monday through Friday schedules, depending on their position. Each Break has a 12-hour day shift and a 12-hour evening shift ensuring there is 24-hour coverage. The staff on Break A and B work according to the Security Schedule developed annually. Each break works a Friday, Saturday, and Sunday every two weeks.

Staff that are scheduled to work Monday through Friday are on flexible schedules. Bon Air Management uses the spreadsheet to create the Daily Duty rosters, which correspond to the individuals that are scheduled on the BAW. Daily Duty rosters are utilized to track staff's time worked for the day that they have been assigned. When there is turnover or someone has been added to the security staff the BAW file is overwritten, and a new file is not created to maintain history of previous employees that were assigned to designated schedules.

The BAW was being overwritten and was not historically maintained so there is no record to indicate when an employee was previously assigned to a particular schedule. Per the Virginia Administrative Code 6VAC35-71-830: Staffing pattern. DJJ must maintain supervision ratios of staff to residents. Keeping the BAWs would give supervisors the ability to compare those scheduled to work with those who worked and evidence compliance with code requirements. It would also provide a history of staff schedules.

The BAW was kept as a working document and not meant to be used as anything but a tool for the Head of Security to help ensure Bon Air was adequately covered on any particular day. Supervisors also do not have independent documentation to support when staff worked versus scheduled and have to rely on the timesheets and duty rosters as their only evidence. During our seven unannounced visits we did not find that Bon Air was not meeting minimum staffing requirements, however, they utilize "drafting" of staff to work extra time to ensure there is adequate coverage.

Recommendations:

1. Ensure the BAWs are maintained as a historical document to support when staff were assigned to work, and that new BAW templates are saved maintaining historical versions.
2. Provide BAWs to supervisors as a tool when they are approving timesheets.
3. Consider maintaining the physical BAWs by storing them with the timesheets pertaining to that 28-day work cycle.

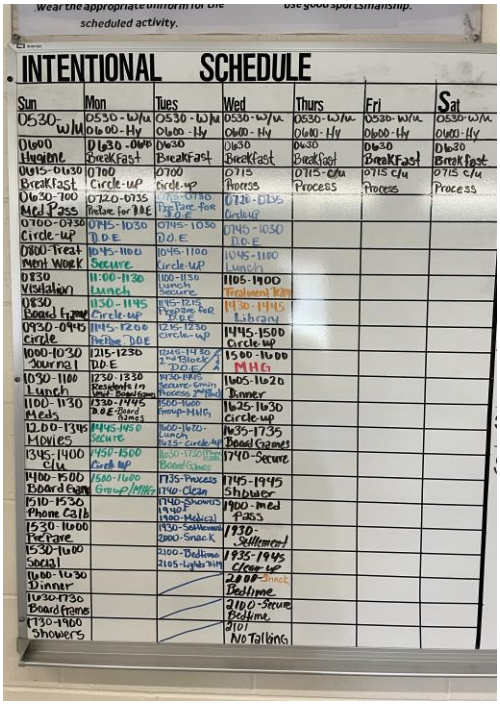
DJJ Management's Response:

Management agreed with the observation and the recommendations as follows:

The Department has historically struggled with the technological and fiscal constraints limiting the ability to move written documentation processes to a more efficient and reliable technology-based applications and processes. Over the past four years, monumental efforts have occurred to address deficiencies in the processes with management structural changes, completion of the fiber project, consultations with external stakeholders and consultants, and the creation and recruitment of an internal facility Scheduling Operations Coordinator, which should allow us the ability to address the concerns and recommendations raised herein. We agree with the recommendations of OSIG for improvement of this process and thank them for their thorough observations.

FINDING 18 - USE OF UNIT INTENTIONAL SCHEDULES WAS NOT ENFORCED

Bon Air has a Universal Daily Schedule that provides Bon Air operational structure from wake-up times to lights out at the end of the day, covering all days including school sessions, weekends and holidays. It provides a framework for when daily activities such as lights on/off, meals and formal counts occur and also details other scheduled activities like education, clinical and counseling services, and intervention programs. Supplementing this is the Unit Intentional Schedule which includes activities specific to Facility Wide-Positive Behavioral Interventions and Support (FW-PBIS) such as the morning check-in, school and workforce classes, and a designated time when residents may visit the incentive area to spend points they have earned for preferred items and activities.



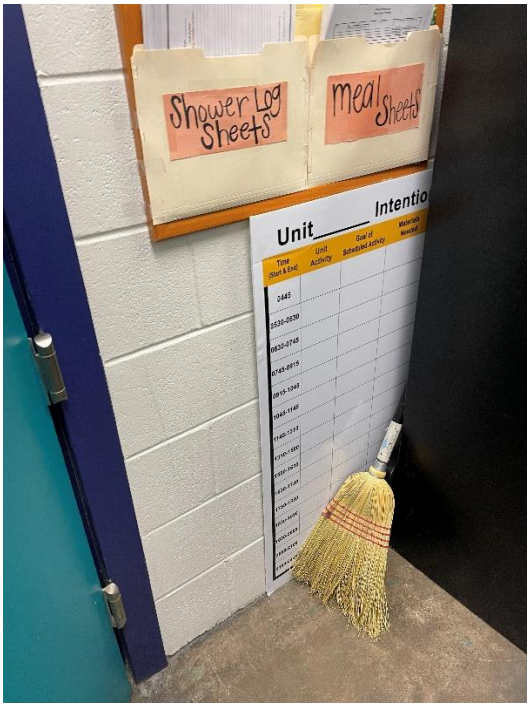
Example of Completed Unit Intentional Schedule

On September 22, 2025, to evaluate resident participation in scheduled activities and assigned tasks, auditors visited each of the 13 occupied units within Bon Air. The review focused on verifying adherence to the weekly Universal Daily Schedule and the supplemental Unit Intentional Schedules for a sample of dates. For each unit, auditors evaluated three days of Unit Intentional Schedules (September 24, September 27 and September 28, 2025) to determine whether they were being implemented as intended.

The following were observations identified from the review:

- Five of 13 units (38%) did not have a Unit Intentional Schedule posted.
- Two of 13 units (15%) had posted schedules that were incomplete.

- Three of 13 units (23%) had posted schedules, but corresponding unit logbooks did not reflect resident movement consistent with the scheduled activities.
- Six of 13 units (46%), did not have unit schedules.



Unit Intentional Schedule

Through discussion with Bon Air's superintendent, it was determined that there is a Universal Schedule that they go by, but there is not a historical unit specific schedule kept for each date. The superintendent conveyed that Unit Intentional Schedules are written on white boards in each unit. Based upon this information, past scheduling details and resident participation in past activities and assigned tasks cannot be validated. Additionally, there is a lack of standardized documentation protocols and oversight to ensure consistent application.

By having designated time frames, Bon Air's environment becomes more predictable and consistent. Additionally, residents' participation in structured activities enables them to develop and apply new skills. The intentionality of the schedule ensures that each period of time has an identified goal, along with clearly defining any materials needed, when the activity will take place, and who is responsible for the delivery of the activity. The Unit Intentional Schedule as a supplement to the Universal Daily Schedule allows anyone who enters the unit to quickly know what is currently happening and what expectations are in place. Together these schedules create both a predictable and structured environment for the residents. Without consistent schedules, staff and residents do not share clear expectations about what activities will occur on the unit on any given day.

Recommendations:

1. Encourage and prioritize PBIS practices related to the use of intentional schedules across all units.
2. Periodically perform staff training on the importance of schedule documentation, its role in supporting resident development, and how to accurately record and maintain schedules.
3. Establish a system to archive Unit Intentional Schedules for a set period of time to allow for historical review and validation by Bon Air management.

DJJ Management's Response:

Management agreed with the observation and the recommendations as follows:

Intentional schedules are a factor of PBIS, which is still in the implementation stage. Not all units have been trained on and fully implemented the universal schedule at this stage of the transition. The Department expects and agrees with the observation that implementation of the universal schedule needs to continue to be finalized in the remaining units, and additional staff training needs to occur.

PBIS has an expected implementation timeline of 3 years for Tier 1 supports. We began implementation on April 1, 2024, and therefore implementation to fidelity is ongoing. As we did not expect perfection at this point in the implementation timeline, we appreciate the assistance of OSIG in helping us to identify areas where attention is needed. Research suggests that Tier 1 supports will eventually work for 80% of youth. Less than halfway through DJJ's implementation timeline we are already seeing success with 66% of our population and expect to continue to improve steadily until reaching or exceeding the 80% mark. We are proud to be ahead of the timeline and the positive response from youth participation and are excited to continue proceeding to full implementation.

In order to promote better Tier 1 practices such as the use of the intentional schedules in each unit, we have developed a Quad Squad Structure for each unit. The Quad Squad consists of the Housing Unit Coordinator, Counselor, Therapist, and a School Representative for each unit. Training of Quad Squads (generally two units per training) began in late spring 2025 and will continue until all units are trained and when staffing changes (promotions, retirement, etc.) necessitate personnel change on the unit. The training focuses on developing and following the intentional schedule. In September 2025, the agency developed Key Performance Indicator (KPI) Audits for selected functions, and one of the functions is the use of intentional schedules. While this is a new process, we have already seen noticeable improvement in the audited areas, driven by the audit process itself and reinforced by supervisory engagement and follow-up.

AUDIT RESULTS

This report presents the results of OSIG's audit of DJJ's Bon Air facility. OSIG performed the following audit testing with immaterial, if any discrepancies noted:

- Timeliness of incident investigations.
- Recognition of facility constraints related to population projections.
- Training and background checks.
- Communication to parents and guardians.
- Initiatives to address employee retention.

Based on the results and findings of the audit test work conducted of DJJ's Bon Air facility, OSIG concluded that internal controls were operating properly, except as identified in the report findings.

APPENDIX I – DJJ RESPONSE TO OSIG REPORT

Amy M. Floriano
Director

Dale L. Holden, Jr.
Chief Deputy Director

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December 4, 2025

Michael Westfall
State Inspector General
Office of the State Inspector General
P.O. Box 1151
Richmond, VA 23218

Re: Office of the Inspector General Bon Air JCC Audit

Dear Mr. Westfall:

I want to thank you and your team for your work in formulating the attached report. The Department appreciates the opportunity and we have included our final responses to your findings.

On February 9, 2025, there was an incident at the Bon Air Juvenile Correctional Center (JCC) related to the Super Bowl. The incident was resolved with no injuries to staff or residents. In concern for the well-being of the residents, the Commission on Youth requested an independent investigation into the conditions at Bon Air. The Office of the Governor reviewed the request and tasked the Office of the Inspector General (hereinafter OSIG) to review the conditions at Bon Air. OSIG determined to proceed with this review by conducting an extensive on-site audit of the Bon Air JCC.

The Department granted OSIG full access to the facility, our documentation system (BADGE), staff, and residents. The team spent numerous hours inside the facility, speaking with residents and staff, and observing facility processes at all hours of the day and night. OSIG left no stone unturned in a detailed, all-encompassing approach. Their dedication to a professional, honest, detailed review of every aspect of the facility was inspiring and exciting for the team at Bon Air JCC to observe. The dedicated staff at Bon Air JCC have long-suffered misconceptions and unsubstantiated allegations from entities lacking in-depth knowledge of the workings of the Department or Bon Air. The demonstrated intent of OSIG to determine the truth of the shortcomings, and challenges, at the facility was a welcomed approach. While their review noted a number of areas for procedural improvement, OSIGs investigation confirmed that the allegations against Bon Air JCC were unfounded. The Department appreciates the efforts and help OSIG has tried to provide us.

The Bon Air facility is old and antiquated, many of the buildings still in use were constructed around 1910. The “expansion” is nearly 30 years old. Three consecutive Department administrations – Democrat and Republican alike – have tried to build newer,

smaller, therapeutic based facilities. All three have been unsuccessful. These efforts have, in part, historically prevented the Department from updating systems at Bon Air given the prospects of new facilities. Over the last four years, however, the Department decided that if Bon Air was the home to our youth in need, we would do what we could to ensure it was updated, as our focus remains on providing the services our youth need.

As anticipated, OSIG identified many of the struggles we have been battling. We are pleased their recommendations acknowledge our resource hurdles, and also that their work uncovered previously unidentified insight into documentation and process deficiencies. While we occasionally disagreed with the interpretation of their observations, we agreed with all of their recommendations for improvement. Perfection is a goal, and not often a reality in any correctional facility. We look forward to enthusiastically incorporating their recommendations and enacting our corrective action plans.

As expected, many of the findings in this report center around resource deficiencies, both financial and personnel, though the two are interconnected. The Department, to varying degrees, has historically struggled with staffing. This became critical early in the COVID crisis, as with many correctional and law enforcement entities across the country and has yet to rebound.

Bon Air currently houses approximately 180 residents, whose average age is 17. Roughly 63% of the population are 18 and older, meaning there are more residents at Bon Air who are 18 and over then there are under 18. Approximately 15% have committed homicide, while approximately 76% percent have committed crimes against a person. These are the most serious offenses. At the same time, our staff are not permitted to use the same physical interventions as staff in the Department of Corrections (DOC), our staff are not permitted to use the same tools as staff at DOC, our staff use utilize trauma informed care with our residents, and our staff are expected to be mentors to our residents. Our staff are woefully underpaid, yet there are those that consider it an achievement when the Department's front-line staff pay finally matches DOC.

Over the last four years, we have worked tirelessly to address the staffing issue at Bon Air. Trying everything from signing bonuses, retention bonuses, focusing on marketing and advertising, and hiring an outside consulting company. We have been running multiple training classes a month, sometimes with as few as three staff, just to get them into Bon Air as soon as possible. This past summer we finally started seeing results from our recruitment efforts. Though we have made progress, staffing and resources remain a challenge. We appreciate our colleagues at OSIG for recognizing this.

It is refreshing to see, that even after a large team of people dedicated months solely to reviewing the activities at Bon Air, many of the allegations lobbed against the facility were unsubstantiated. There was no evidence or indication of instances of harm, mistreatment or danger uncovered. Despite the inherent danger of the behavior of the residents themselves, the residents continue to be safe, protected and well cared for by the Department. This is always the main concern, especially given the unfortunate struggles of escapes, attempted escapes, and suicides predating this administration.

The Department of Juvenile Justice's staff, from the bottom all the way to the top, is comprised of individuals who have not only dedicated their careers to public service, but have taken on the task of caring for young people in our Commonwealth, be they in the community or in a

secure facility. In many ways, the Department is one of last chance, or last resort. The Department, through its staff, embraces this challenge and is dedicated to doing everything in our collective power to rehabilitate the youth sent to us by providing individualized therapeutic interventions. These interventions take time, they take significant resources, and they take sufficient staff to provide them. We welcome new ideas and suggestions and are dedicated to working with those that want to help us in our mission.

Sincerely,

Amy Miller Floriano

APPENDIX II – CORRECTIVE ACTION PLAN

FINDING NO.	RECOMMENDATION	CORRECTIVE ACTION	DELIVERABLE	ESTIMATED COMPLETION DATE	RESPONSIBLE POSITION
1 - Evidence is Lacking to Ensure Visual Wellness Checks Are Performed	1. Ensure confinement monitoring checks are performed and forms are properly retained as required by the Library of Virginia retention schedule. 2. Ensure confinement monitoring forms are properly documented each time a visual check is performed. The documentation should include the time and initials of the staff performing the visual check. 3. Ensure logbooks identify SIB residents and any notes on significant events impacting those	1. Identify and prepare the single, secure, centralized repository dedicated solely to retained Confinement Monitoring Forms. The repository will be accessed only by authorized personnel and tracked by a control log which will be audited semi-annually by the JCC Compliance Manager. 2. Conduct mandatory, hands-on remedial training for all staff responsible for performing and documenting confinement checks. To reinforce the training, the JCC Compliance Manager will perform unannounced floor observations to visually confirm that staff are documenting the required time and initials immediately upon performing the check. 3. Conduct mandatory, hands-on training for all	1. The JCC Compliance Manager's audit documentation and the control log 2. Training rosters and documentation of unannounced rounds observations by the JCC Compliance Manager. 3. Training rosters, daily SIB audit tool and documentation of JCC Compliance Manager's quarterly reviews and unannounced floor observations. 4. Log entries and	March 1, 2026	Deputy Director of Education and Rehabilitative Care

FINDING NO.	RECOMMENDATION	CORRECTIVE ACTION	DELIVERABLE	ESTIMATED COMPLETION DATE	RESPONSIBLE POSITION
	residents that should be communicated for other unit staff. 4. Develop a process to ensure that confinement monitoring forms are reviewed by a supervisor to ensure that all residents behind a secure door are properly monitored.	security staff on the SIB Protocol to be reinforced by developing a daily quality assurance tool (SIB audit tool) used by Assistant Watch Commanders to check the logbook entries against the current list of residents on SIB precautions. The tool verifies 1) Correct flagging of SIB residents and 2) Adequate logging of any significant events. The JCC Compliance Manager will conduct a quarterly review of the daily SIB audit tool and perform unannounced floor observations to check the logbook entries. 4. Develop supervisor auditing protocol for Housing Unit Coordinators, Area Supervisors, and Assistant Watch Commanders to review Confinement Monitoring Forms during their housing unit inspections	documentation of the JCC Compliance Manager's quarterly reviews and unannounced floor observations.		

FINDING NO.	RECOMMENDATION	CORRECTIVE ACTION	DELIVERABLE	ESTIMATED COMPLETION DATE	RESPONSIBLE POSITION
		and log their review with the time and their initials. The JCC Compliance Manager will conduct a quarterly review of the supervisor audits and perform unannounced floor observations.			
2 - Rehabilitative Outcomes Are Compromised When Therapeutic Services Are Not Provided Timely	1. Consider increasing BSU staffing levels to ensure adequate therapist coverage across all units and treatment programs. 2. Develop and implement a contingency plan to maintain therapy coverage during staff absences or separations, such as the use of contract or part-time therapists. 3. Enhance monitoring and oversight of	1. a. Conduct an assessment of all positions allocated to the Behavioral Services Unit to ensure there is sufficient allocation of resources to meet the service needs of the residents across all units. The assessment will build on the changes implemented thus far to include the reorganization of the CAP BSU staff being repositioned at Bon Air. b. If additional positions are identified through the assessment, work towards identifying resources/funding to meet the need. c. In collaboration with Human Resources,	1. a. Assessment of all positions of the BSU to identify how to appropriately structure resources and allocate resources accordingly b. Recruitment prioritized for all vacant positions and positions filled. 2. a. BSU will complete a comprehensive systems review and implement a	July 1, 2026	Deputy Director Placement & Program Implementation Deputy Director of Education & Rehabilitative Care Deputy Director of Policy Deputy Director of Administration and Finance Director of Service Programs & Violence Intervention

FINDING NO.	RECOMMENDATION	CORRECTIVE ACTION	DELIVERABLE	ESTIMATED COMPLETION DATE	RESPONSIBLE POSITION
	treatment scheduling and documentation in BADGE to ensure therapy sessions occur at the required frequency.	implement any classification changes with current positions to identify any additional reorganization to maximize coverage and increase efficiencies; prioritize recruitment for any vacant positions. 2. a. BSU will conduct a system review of resource and service allocation across the Bon Air campus. b. BSU will develop a plan, based on the system review, to ensure coverage of all treatment programs across the facility. c. Facilitate gap analysis of service delivery and implement a plan to utilize the RSC model to supplement service delivery for residents. d. Identify provider(s) based on the gap analysis who can provide identified services. e. Coordinate with Bon Air & maintenance staff to work	strategic plan employing strategies to maintain therapy during staff absences. b. Implementation of contracted services based on the gap analysis, in coordination with DD of education and rehabilitative care, by the end of the year. c. Develop and implement continuous quality improvement meetings to ensure alignment, quality of service delivery and identify ongoing needs across all direct care		

FINDING NO.	RECOMMENDATION	CORRECTIVE ACTION	DELIVERABLE	ESTIMATED COMPLETION DATE	RESPONSIBLE POSITION
		towards identifying and purposing therapeutic space to deliver contracted services with appropriate security supervision. f. Work towards identifying resources to implement contracted services to support and supplement current BSU services g. Implement ongoing implementation meetings across BSU, Bon Air, QA and the provider to problem solve any barriers and ensure alignment with service delivery for the residents. 3. a. BSU will develop and implement a continuous quality improvement plan delineating how to increase monitoring and oversight of treatment scheduling, in collaboration with education, security and casework staff. b. BSU will implement weekly clinical supervision meetings to plan, consult, and	residents based on needs and LOS. 3. a. Implementation of a CQI plan with quarterly reviews and updates. b. Weekly supervision schedule is implemented across therapists and respective supervisors. c. A data tracker will be created and implemented to collect critical data points to assess progress. BSU will utilize the new services tab in BADGE once it is deployed. All BSU staff will participate in the		

FINDING NO.	RECOMMENDATION	CORRECTIVE ACTION	DELIVERABLE	ESTIMATED COMPLETION DATE	RESPONSIBLE POSITION
		clinically assess each resident's participation and progress in treatment. c. BSU will collect and track data to assess performance of staff.	training.		
3 - Residents Enrolled in Educational Programs Were Late or Not Attending Class	1. Ensure that all instructional staff are trained on proper documentation in PowerSchool and establish accountability for daily compliance. 2. Engage educational, clinical, and security staff to identify and mitigate barriers to attendance and punctuality, including behavioral and scheduling challenges.	1. Reiterate the requirements of the instructions for entering attendance. 2. Create two Lead School Safety Officer positions to enhance operational coordination. 3. School Attendance Clerk will monitor attendance and report out at monthly "Data Talks" as well as to the Deputy Director of Education and Rehabilitative Care	1. Documentation of receipt of written instructions by all instructional staff. 2. Hire two Lead School Safety Officers. 3. Attendance reporting will be included on the Deputy Director of Education and Rehabilitative Care's monthly report	March 1, 2026	Deputy Director of Education and Rehabilitative Care

FINDING NO.	RECOMMENDATION	CORRECTIVE ACTION	DELIVERABLE	ESTIMATED COMPLETION DATE	RESPONSIBLE POSITION
	3. Generate and review periodic attendance and punctuality reports to detect trends, implement corrective action, and promote continuous improvement in educational engagement.				
4 - Vocational and Post-Secondary Programming Are Often Unavailable to Residents	1. Hire additional instructors for Vocational and Post-Secondary Programs. 2. Develop and implement processes to retain qualified educators and expand available educational offerings. 3. Ensure that Bon Air is tracking and coordinating all vocational services offered.	1. Continue targeted recruitment in collaboration with Human Resources to fill open trades instructor positions. Outreach efforts include marketing campaigns to attract industry professionals, partnerships with local trade organizations, and engagement with a temporary employment agency to identify qualified trades instructors. 2. Continue to focus on retention through professional development	1. • Recruitment plan • Documentation of job postings • Recruiting records for new trade instructors 2. • Professional development calendar • Draft EWP and identified possible funding sources for a	March 1, 2026	Deputy Director of Education and Rehabilitative Care

FINDING NO.	RECOMMENDATION	CORRECTIVE ACTION	DELIVERABLE	ESTIMATED COMPLETION DATE	RESPONSIBLE POSITION
	4. Properly track resident sentence requirements for vocational training in addition to seniority, date of request/interest by residents, and other determining factors as part of developing a waiting list to track future demand for vocational courses.	and by exploring the addition of a dedicated specialized coaching position specific to trade instructors to help bridge the skill and art of teaching with the technical knowledge of the trades field. This position could provide individual support, instructional coaching, and mentorship to strengthen instructional quality and improve instructor retention. Continue to implement credential-based trainings aligned with workforce needs through its partnership with the Community College Workforce Alliance (CCWA). This ongoing collaboration ensures residents have access to industry-recognized certifications and training opportunities that align with	specialized trades instructional coach position • Course catalog or program list identifying credential-based trainings available to residents 3. • Published Programs of Studies document for Bon Air's educational offerings. • School counseling meeting logs • Academic and career plans • Career assessment summaries • Student		

FINDING NO.	RECOMMENDATION	CORRECTIVE ACTION	DELIVERABLE	ESTIMATED COMPLETION DATE	RESPONSIBLE POSITION
		current labor market demands. 3. During the 2024–2025 school year, the Division implemented a comprehensive *Programs of Studies* document that details all secondary and post-secondary options. This document is used by staff, students, and families to ensure awareness and alignment of offerings. School counselors will continue to meet with each student to review career assessment data, academic and career plans, and release timelines to ensure accurate program placement. Transition Specialist and Career and Academic Coordinator will continue to create individualized	portfolios 4. • Enrollment data generated from the student information system. • School counselor data log documenting Tier 4 and Tier 5 student information.		

FINDING NO.	RECOMMENDATION	CORRECTIVE ACTION	DELIVERABLE	ESTIMATED COMPLETION DATE	RESPONSIBLE POSITION
		portfolios that include all certifications earned and college transcripts. These portfolios are shared with Reentry Advocates to facilitate smooth reentry into the community. 4. Enrollment is currently tracked through the student information system, and school counselors maintain detailed data logs for Tier 4 and Tier 5 students to prioritize based on release date.			
5 - Inefficient Resident Movement Impacts Coordinated Activities	1. Review and update operational procedures related to resident movement to reflect current operations and to include processes designed to optimize resident movement using	1. Review Movement & Supervision of Residents procedure and update as appropriate, to include movement responsibilities of any newly established positions as well as any identified process improvements 2. Explore infrastructure	1. Revised procedure 2. Proposal for improvements 3. Training rosters 4. Show improvement	December 31, 2026	Deputy Director of Education and Rehabilitative Care

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	available tools such as controlled doors, resident staging, and communication where applicable. 2. Identify and assess the feasibility of infrastructure improvements that, along with process improvements, may enhance the safety, efficiency, and operational consistency of resident movement. 3. Ensure that Bon Air staff are trained on how to efficiently and safely prepare for and facilitate resident movement. 4. Hire and retain sufficient staffing to facilitate resident movement.	improvements and the resources required to implement and develop a proposed plan 3. Provide experiential training of expected preparation for resident movement 4. Continue to recruit and retain staff			

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6 Evidence Is Lacking To Ensure Residents Have Consistent, Daily Access to Large Muscle Exercise	1. Ensure large muscle exercise is provided to residents as required and that this exercise is adequately and accurately documented. 2. Determine if manual documentation of large muscle exercise is an effective, efficient method of documentation. If so, they should: a. Review and revise the policy on logbooks to ensure that all required entries are necessary and feasible. b. Ensure that staff are trained in what should be documented. c. Ensure there is sufficient staffing to maintain accurate logbooks.	1. Conduct an assessment of current programming to calculate the average daily time dedicated to large muscle exercise (e.g., gym, outdoor recreation, structured physical education). Review unit intentional schedules for incorporation of large muscle exercise each day. Review logbook procedure Develop audit checklist Continue to recruit staff 2. Conduct a formal review of the manual logging process (time spent, error rates) versus alternative methods. Management will issue a documented decision on whether to retain or replace manual documentation. Train Housing Unit Coordinators and Area Supervisors on their role as the primary quality assurance checkpoint for their assigned	1. Unit intentional schedules with daily incorporation of large muscle exercise. Audit documentation Recruiting reports 2. Decision on manual vs. alternative methods. Training rosters 3. Identified platforms and funding sources.	September 30, 2026	Deputy Director of Education and Rehabilitative Care

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	d. Ensure that logbooks are reliable. e. Ensure that the paper documentation is consistently completed by all staff and units. 3. Identify a better process (including potential digital systems) for documenting large muscle exercise, if it is determined that the manual documentation process is not effective.	unit/area. This includes coaching methods for immediately addressing deficient entries made by staff under their supervision before the shift ends. 3. Explore digital platforms and determine minimum requirements for IT as well as functionality for staff. Identify possible funding for procuring a digital platform.			
7 - The Well Being of Residents In Special Housing Could Not Be Verified Due To Deficiencies In Procedure Updates, Documentation, And Monitoring	1. Special Housing standard operating procedures should be updated to incorporate and reflect all relevant bulletins and procedural changes. 2. Management should ensure special housing procedures and protocol are followed including:	1. Update Standard Operating Procedure (SOP) for Special Housing. 2. Develop and distribute mandatory, one-page daily checklists for all security supervisors outlining all "core" procedures including approval requirements, mandatory fields on forms, and verification of observation checks.	1. Room Confinement (VOL IV 4.1-2.28), effective December 1, 2025. 2. "Core" procedures checklist Form review tool Training rosters 3. Standardized	June 1, 2026	Deputy Director of Education and Rehabilitative Care

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	a. handwritten signature approvals on forms, b. completion of all applicable document sections, and c. resident room checks in 15-minute intervals. 3. Management should conduct training as needed and perform quality assurance reviews to verify the completeness and legibility of logbook entries and confinement monitoring forms. Results of quality assurance reviews should be reported to DJJ leadership. 4. Management should require and retain all confinement approval forms for all special	Create a tool that requires Assistant Watch Commanders or their designee to conduct a review of all room confinement approval forms and monitoring forms on their assigned shift to check for the presence of appropriate signatures, mandatory services, completion of all fields, and verifiable observation checks made no more than every 15 minutes. Conduct a mandatory refresher training for all direct care staff (including supervisors) to cover the areas of non-compliance identified. 3. Create a standardized guide defining required entry content, approved abbreviations, and legibility standards. Conduct mandatory training for all staff required to complete logbook or	Entry Guide Training rosters 4. JCC Compliance Manager's tracking system, including electronic copies of the confinement packet		

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	housing placements in accordance with agency retention policies.	confinement monitoring entries. Training must be hands-on, utilizing the new Standardized Entry Guide, and must explicitly address the identified top 5 errors. Housing Unit Coordinators and Area Supervisors will receive specific instruction on their role as the primary checkpoint for their assigned unit/area. This includes coaching methods for immediately addressing deficient entries made by staff under their supervision before the shift ends. 4. The shift commander will scan a copy of the completed room confinement request form to the JCC Compliance manager. The shift commander on duty when the room confinement ends, will review the confinement forms and submit the completed packet to the JCC Compliance			

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		Manager. The JCC Compliance Manager will retain and track room confinement forms.			
8 - Documentation of Incidents and Grievances Needs to be Improved	1. Ensure that current processes and documents are implemented in a manner that captures all required information and addresses issues timely, including: a. Forms are signed and dated by the appropriate staff member and/or reviewer. b. Incidents include the type of incident. c. Actions taken are documented. d. Residents are signing the forms.	1. Update procedure to include clarification of expectations from the Bon Air JCC Action Notification Provide refresher training to all security series staff regarding the Resident Grievance Procedure and Incident Reporting Procedure and their responsibilities in the process. 2. Explore tools and resources to streamline the incident reporting and grievance processes. 3. The Resident Rights and Legal Support Manager will conduct unannounced quarterly audits of resident grievance and complaint forms and the results will be	1. a. Updated procedure b. Training rosters 2. Proposal for identified improvements 3. Audit documentation	June 1, 2026	Deputy Director of Education and Rehabilitative Care Deputy Director of Policy

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	e. The final determinations are documented by the HRC. 2. Work to identify potential improvements to reduce administrative burden and lessen the potential for errors in documentation and untimely actions. 3. Ensure that a quality assurance process is implemented to review a sample of grievances and incidents to ensure that the process is working as intended and that issues are properly addressed. These results should be reported to DJJ leadership.	communicated to the HRC team and DJJ leadership for process improvement and performance deficiencies addressed with individual staff, as necessary.			
9 - Resolution Of Resident Concerns Were Not Adequately	1. Implement a standardized meeting minute template that	1. Develop a meeting minute template that includes clearly labeled sections for: Resident	1. Meeting minute template 2. Tracking log	June 1, 2026	Deputy Director of Education and Rehabilitative

FINDING NO.	RECOMMENDATION	CORRECTIVE ACTION	DELIVERABLE	ESTIMATED COMPLETION DATE	RESPONSIBLE POSITION
Documented	includes clearly labeled sections for resident concerns, responsible staff, action steps, and resolution status. 2. Develop and maintain a centralized tracking log of all resident concerns raised during RAC meetings, updated regularly to reflect follow-up actions and outcomes. 3. Ensure that meeting minutes explicitly state when no concerns are raised to avoid ambiguity. 4. Apply consistent formatting and categorization of concerns across all meeting records to support effective tracking and analysis.	Concerns, Responsible Staff, Action Steps, and Resolution Status. 2. Develop and implement an electronic tracking log designed to record every concern from the minutes 3. Add "No concerns" section to meeting minute template to be used when applicable. 4. Review and update SOP IV -4.1 – 4.07 Resident Council to reflect current practices and documentation requirements	3. Meeting minute template 4. Updated procedure		Care Deputy Director of Policy

FINDING NO.	RECOMMENDATION	CORRECTIVE ACTION	DELIVERABLE	ESTIMATED COMPLETION DATE	RESPONSIBLE POSITION
10 - Resident Good Behavior Points Can't be Verified	1. Ensure that the spreadsheets maintained for the points earned by residents contain enough detail so that the amounts can be traced back to supporting documentation. 2. Ensure that points cards are turned in daily for every resident no matter how many points are earned. 3. Ensure that point cards are maintained for at least 90 days in accordance with the FW-PBIS Manual. 4. Develop a process to spot check and reconcile point cards on a cyclical basis to ensure that point balances are properly maintained.	1. Modify how we currently track what points are added and removed and improve file saving practices. 2. Since PBIS is supposed to take 3 years to implement Tier 1 supports, we are proud to have completed 50% of our FWPBIS Implementation checklist (pulled and modified from PBIS.org) in under 1.5 years. This is a 19% increase in the last 6 months. In order to ensure collection of FWPBIS point cards, DJJ will continue to implement the system as planned and reinforce the components as we work towards fidelity. 3. This observation was remedied almost immediately. As of November 3rd, there are 90 days or more of backlogged FWPBIS Point Cards. In	1. FWPBIS Additional Points Tracker, include additional charge detail on FWPBIS Order Withholding Spreadsheet, FWPBIS Point Tracker update saved daily. 2. As of November 1, 2025, units are collectively submitting FWPBIS Point Cards on time 94% of the time. This is regardless of the number of points earned. 3. 90 days or more of backlogged FWPBIS Point Cards.	December 31, 2025	Deputy Director of Education and Rehabilitative Care

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		addition, either the Director of Behavior Analysis or the Behavior Analytic Administrator must approve the destruction of any FWPBIS Point Cards. 4. Crosstrain all Behavior Analysis Team (BAT) staff on point tracking and conduct routine internal audits.	4. Internal audit desk procedure for BAT administrators		
11 - High Turnover and Short Tenure of Bon Air Staff Undermine Workforce Stability and Service Delivery	1. Perform or request a classification and compensation review of the Security Officer III and IV roles to help ensure that compensation aligns with similar positions in the industry. 2. Explore targeted retention strategies, such as mentorship programs, early-career support, other allowable options to help improve retention.	1. Request and secure contract to perform an independent compensation and classification analysis for the JCS position that explores similar positions from all public sectors, as well as private entities. Will also request DHRM to perform an internal review of the same data on smaller scale based on internal analysis that DJJ HR will perform. The information from completion of both analysis can be used in future requests	1. Solicit request for independent analysis by March 30th. Scope will request completion date by October 1, 2026. DJJ to perform internal compensation and classification analysis of the JCS roles by January 31, 2026. That data will then be sent to	October 1, 2026	Deputy Director Administration and Finance Deputy Director of Education and Rehabilitative Care

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	3. Collaborate with DHRM and other stakeholders to identify long-term solutions for workforce stability, including potential legislative or budgetary changes.	and decisions. 2. Review and Revise the Staff Support Protocol Research successful retention strategies used in similar correctional environments. Institute a formal mentorship program pairing staff seeking advancement with an experienced employee or supervisor Institute the Professional Action Plan for all JCS staff that includes SMART goals, and identified resources 3. DJJ to request and work to implement ongoing workgroup with representatives from DHRM, PSHS Secretariat, DPB and other state agencies.	DHRM for review and feedback by February 28, 2026. 2. Updated Staff Support Protocol Finalized protocols for the BAJCC mentorship program and the Professional Action Plan Mentor/Mentee Pairing Tracker with tracked compliance of minimum check-ins 3. Identify stakeholder representatives and request participation by February 1, 2026. Hold kick-off meeting by May		

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			30, 2026.		
12 - Fragmented Health Record Systems Risk Resident Safety and Continuity of Care	1. Management should implement an EHR system that consolidates both behavioral and general medical health records into a single, unified platform. This platform should: a. Develop and enforce consistent standards for record content, organization, and retention within the system. b. Provide comprehensive training to all clinical staff on using the EHR system and maintaining complete, accurate records. 2. Management should determine if it is necessary to continue	1. Continue to pursue budget request and consult with DOC on their experience with DOCHealth and contract rider options. 2. a. Create an inventory of all clinical data repositories (electronic systems, shared drives, and paper records) currently used by medical and behavioral health services staff, noting the type of data held (e.g., medication logs, psych evaluations, dental notes) and a determination of the necessity of the data kept. b. Based on the functional determination, identify and designate a single, accessible, unified platform (e.g., the requested EHR, or an approved secure network location) that will serve as the primary source for all clinical data.	1. a. Documentation of DJJ receipt of approval to submit budget request for EHR System – September 2025. b. Schedule stakeholder engagement meeting to further explore DOC system by January 15, 2026.	September 30, 2026	Deputy Director of Education and Rehabilitative Care Deputy Director of Placement and Programs Deputy Director of Administration and Finance

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	to use separate paper records for BHR and medical records, and if not, every effort is made by Bon Air to foster access to a single, unified paper health record in a location that is accessible to all healthcare providers.				
13 - Gaps were Identified in Emergency Preparedness Compliance and Recordkeeping	1. Implement a centralized tracking system to ensure all required emergency drills and tabletop exercises are scheduled, conducted, and documented across all shifts and units. 2. Ensure there is someone responsible for maintaining the supporting documentation of drills,	1. Implement a centralized tracking system to ensure all required emergency drills and tabletop exercises are scheduled, conducted, and documented across all shifts and units. 2. Assign staff responsible for maintaining the supporting documentation of drills, tabletop exercises, and actual emergencies Explore additional funding/resources to ensure staff can be dedicated to	1. Tracker listing all required emergency drills and tabletop exercises 2. Inclusion of the responsibilities in EWPs. 3. Report of missing or outdated emergency preparedness activities and documentation of remedial	May 1, 2026	Deputy Director of Education and Rehabilitative Care

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	tabletop exercises, and actual emergencies. 3. Identify and address any missing or outdated emergency preparedness activities. 4. Ensure a responsible part is assigned to perform a quality assurance review to ensure that documentation of drills, table exercises, and corresponding after action reports are properly performed, maintained, readily available, and results are reported to management.	these tasks. 3. Identify and perform any missing or outdated emergency preparedness activities. 4. JCC Compliance Manager will develop an audit tool and conduct audits on documentation of drills, table exercises, and corresponding after action reports, and report to facility and agency leadership. Explore additional funding/resources to provide staffing assistance to the JCC Compliance Manager as a large number of critical responsibilities are falling to this position.	performance. 4. Audit documentation		
14 - Internal Controls for Timesheets of Overtime and Premiums were Lacking	1. Ensure timesheets are retained based on the schedule established by the Library of Virginia. 2. Ensure that employees understand the timing for	1. Develop a Records Custodian position description intended to support the JCC Compliance Manager and track Library of Virginia record retention schedules for relevant	1. a. Records Custodian EWP b. Training rosters c. The JCC Compliance Manager's audit	March 30, 2026	Deputy Director of Education and Rehabilitative Care

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	payment of overtime worked. 3. Ensure employees sign their timesheets, to verify that they agree with the hours worked.	documentation. Explore funding options to create the Records Custodian position. Train relevant staff on timesheet processing and retention to include the consequences of non-compliance. The JCC Compliance Manager will perform a semi-annual audit of a random sample of retained timesheets to verify that they are physically present, stored in the correct secure location, and held no longer than the date dictated by the confirmed Library of Virginia retention schedule. Explore possible platforms for automated timekeeping, including compatibility with existing personnel record keeping systems. 2. Distribute memo explaining timing for payment of overtime worked,	documentation 2. Memo and training rosters. 3. Timesheet rejection log and the JCC Compliance Manager's audit documentation.		

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		along with timeline for submission and cutoff dates. Provide follow-up training. 3. The Bon Air Timekeeper will maintain a timesheet rejection log and inform the Superintendent of all timesheets rejected due to missing signatures prior to the payroll cutoff. The JCC Compliance Manager will conduct a quarterly audit of a random sample of retained timesheets to verify that both the employee's signature and the supervisor's signature are consistently present on every sampled form, confirming sustained compliance with the verification requirement. Explore possible platforms for automated timekeeping, including compatibility with existing personnel record keeping systems.			
15 - Paper Records Hinder Oversight by	1. Decide if continuing the manual	1. Analyze the following processes for possible	1. List of processes and	October 1, 2026	Deputy Director of Education and

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Agency Leadership	documentation of processes on paper is the best use of resources. If it is decided to continue the process, they should consider: a. Providing summaries of important things that happened on the unit for shift change updates rather than logbooks. b. Ensuring that the paper documentation is consistently completed by all units. c. Keeping the documentation in ways that allow easy accessibility when information about residents are needed. 2. Investigate systems able to alleviate their	transition to automated platform(s) and for improvement in communication and retention: ➢ Unit Logbooks ➢ Confinement Monitoring Forms ➢ Grievance Forms ➢ Health Records ➢ Timesheets ➢ Break Assignment Worksheets ➢ Special Housing Requests ➢ Point Cards 2. Investigate options for automating and/or storing documents in an electronic format 3. Seek assistance from the Department of Planning and Budget on a budget request for one or more automated systems to meet the needs of the facility, including the cost of implementing the system	determination of whether to transition or how to improve. 2. List of possible electronic systems for any process determined to be appropriate for transition to automated platform. 3. Prepare and submit Decision Package for automated software solution in Fall 2026 (for funding in FY 2028) with the assistance of DPB		Rehabilitative Care Deputy Director of Administration and Finance

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	reliance on documenting processes on paper. 3. Work with the Department of Planning and Budget on a budget request for an automated system to meet the needs of Bon Air. The request should include the cost of implementing the system based on infrastructure and maintaining the system.	based on infrastructure and maintaining the system.			
16 Bon Air Lacks Updated Procedures	1. Update all core operational policies and procedures prioritizing those impacting safety, security, and compliance. 2. Ensure annual reviews, approvals, and documentation of all procedures is occurring. 3. Ensure staff are updated when there are policy and procedure	1. Collaborate with Facility leadership to determine which procedures are "core." Analyze work required to more systematically review and update these "core" procedures. As necessary, attempt to secure funding or resources to create additional positions dedicated to updating the core residential procedures. 2. Develop a process to record	1. a. Post and fill positions dedicated to reviewing and updating core residential procedures. b. Review and, as necessary, update "core" procedures. 2. a. Develop and promulgate a	December 31, 2026	Deputy Director of Policy Division Deputy Director of Administration and Finance

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	changes that impact their job duties. 4. Consider implementing a centralized digital policy management system with version control, change tracking, and automatic review reminders.	when leadership reviews procedures during the regular course of business to formally capture that this review occurs. Require leadership to review remaining procedures by year end, keeping a record of said review. Research software that may assist in this tracking and attempt to obtain funding for purchase. 3. While new procedures are promulgated to all staff, develop a process to keep track of staff review of newly issued procedures. In collaboration with IT, research and obtain funding for a digital tracking system to promulgate and record distribution and review. 4. In collaboration with IT, research central digital policy management system to determine if one may be obtained that fits the need of	procedure for facility leadership to review all facility procedures on an annual basis and keep track of said review. b. All, approximately 170, facility procedures reviewed and recorded via new process by facility leadership by end of 2026. 3. Develop and implement a procedure for the issuance of procedures and the tracking of the receipt of said issuance. 4. Utilize technology to streamline the		

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		the Department in an effort to streamline the procedure development process.	procedure development process.		
17 - Break Assignment Worksheets To Assist With Adequate Staffing Levels Are Not Maintained	1. Ensure the BAWs are maintained as a historical document to support when staff were assigned to work, and that new BAW templates are saved maintaining historical versions. 2. Provide BAWs to supervisors as a tool when they are approving timesheets. 3. Consider maintaining the physical BAWs by storing them with the timesheets pertaining to that 28-day work cycle.	1. Develop Shift Assignment Worksheets from the BAW for each shift that will include the date the employee joined the shift and archive the previous version in electronic and paper formats. 2. Train shift commanders on utilizing the Shift Assignment Worksheet when processing 28-day cycles. 3. Shift Commanders shall email an electronic copy of their shift's 28-day cycle sheets using the Shift Assignment Worksheet as the cover page to the timekeeper and Chief of Security or designee. The Chief of Security or designee shall digitally track receipt of shift assignment worksheets and maintain an electronic and physical file of the documentation.	1. Updated Shift Assignment Worksheets, including archived versions 2. Training rosters 3. Tracking document and both electronic and physical records of the submitted 28-day cycle sheets and cover worksheets	January 31, 2026	Deputy Director of Education and Rehabilitative Care

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18 - Use of Unit Intentional Schedules Was Not Enforced	1. Encourage and prioritize PBIS practices related to the use of intentional schedules across all units. 2. Periodically perform staff training on the importance of schedule documentation, its role in supporting resident development and how to accurately record and maintain schedules. 3. Establish a system to archive Unit Intentional Schedules for a set period of time to allow for historical review and validation by Bon Air management.	1. Include announcements/reminders about PBIS practices at each muster. The Planning and Analysis Coordinator will perform KPI Audits on the Housing Unit Coordinators that address the use of the intentional schedule. 2. Continue to provide Quad Squad training as new staff is hired that comprise the Quad Squad for each unit. The Planning and Analysis Coordinator will perform KPI Audits on the Housing Unit Coordinators that address the use of the intentional schedule. 3. Explore space needed to store printed weekly and/or electronic weekly unit intentional schedules based on relevant Library of Virginia Retention Schedule.	1. Muster minutes KPI Audit records 2. Training rosters and materials, KPI Audit records 3. Plan for archiving weekly unit intentional schedules, to include length of retention and location.	March 1, 2026	Deputy Director of Education and Rehabilitative Care