MARLANA R. VALDEZ
Director

October 7, 2010

The Honorable Thomas V. Miller, Jr., President of the Senate
Maryland General Assembly, H107 State House
Annapolis, MD 21401

The Honorable Michael E. Busch, Speaker of the House
Maryland General Assembly, H101 State House
Annapolis, MD 21401

The Honorable Donald DeVore, Secretary
Department of Juvenile Services, One Center Plaza, 120 West Fayette Street
Baltimore, Maryland 21201

Rosemary King Johnston, Executive Director
Governor's Office for Children, Office of the Governor
301 W. Preston Street, Suite 1502
Baltimore, MD 21201

Members of the State Advisory Board on Juvenile Services
c/o Department of Juvenile Services, One Center Plaza, 120 West Fayette Street
Baltimore, Maryland 21201

Dear Mr. President, Mr. Speaker, Sec. DeVore, Ms. Johnston, and State Advisory Board Members:

Enclosed please find a Special Report of the Juvenile Justice Monitoring Unit of the Office of the Attorney General. This report pertains to a staff fatality at the Cheltenham Youth Facility. The Department of Juvenile Services (DJS) Response is also included.

I would be pleased to answer any questions you may have about this report. I can be reached by email at mvaldez@oag.state.md.us and by phone at 410-576-6953 (o) or 301-257-5399 (c). All reports of the Juvenile Justice Monitoring Unit are also available on our website at www.oag.state.md.us/jjmu.

It has been an honor to work with all of you to improve services provided to the youth of Maryland.

Respectfully submitted,

Marlana Valdez

Marlana R. Valdez
Director
Juvenile Justice Monitoring Unit

Cc: The Honorable James Brochin, Maryland State Senate
The Honorable Brian Frosh, Maryland State Senate
The Honorable Nancy Jacobs, Maryland State Senate
The Honorable Nancy King, Maryland State Senate
The Honorable C. Anthony Muse, Maryland State Senate
The Honorable Robert A. Zirkin, Maryland State Senate
The Honorable Kathleen Dumais, Maryland House of Delegates
The Honorable Adelaide Eckardt, Maryland House of Delegates
The Honorable Ana Sol Gutierrez, Maryland House of Delegates
The Honorable Susan Lee, Maryland House of Delegates
The Honorable Gerron Levi, Maryland House of Delegates
The Honorable Anthony J. O'Donnell, Maryland House of Delegates
The Honorable Victor Ramirez, Maryland House of Delegates
The Honorable Luiz R.S. Simmons, Maryland House of Delegates
The Honorable Nancy Stocksdale, Maryland House of Delegates
The Honorable Joseph Vallario, Maryland House of Delegates
The Honorable Jeff Waldstreicher, Maryland House of Delegates
The Honorable Nancy Kopp, Treasurer's Office
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MARLANA R. VALDEZ
Director

SPECIAL REPORT
CHELTENHAM YOUTH FACILITY
SEPTEMBER, 2010

Facility: Cheltenham Youth Facility
11001 Frank Tippett Road
Cheltenham, MD 20623

Subject: Staff Member Fatality

Investigated by: Nick Moroney, Jamaal Stafford, Marlana Valdez

Date of Report: September 2010

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INTRODUCTION

On February 17, 2010, Hannah Wheeling, an English teacher in the ReDirect program at the Department of Juvenile Services (DJS/the Department) Cheltenham Youth Facility (CYF/Cheltenham), was killed. A 14-year-old youth who was a student in the program[1] has been charged in the killing.

Cheltenham is a secure detention center for boys located in Prince George's County. At the time of Ms. Wheeling's death, in addition to the fenced-in secure detention center, two other programs operated outside the security fence on the Cheltenham campus – a 5-bed shelter and the ReDirect program, a 24-bed short-term residential program, housed in Murphy Cottage.

The ReDirect program was an Impact Program that provided intensive intervention for low to moderate risk youth. DJS also operates an Impact Program at one of the Youth Centers in western Maryland which provides 90-day short-term residential intervention.

Because the two DJS Impact Programs are located on the campuses of more secure facilities, they operate as hybrids of a sort. In some respects, their operations are similar to group homes with less security than secure detention or treatment centers. Youths' rooms are not locked at night, and no surveillance cameras or special security hardware is installed.

At the same time, their programs share characteristics with secure programs. All activities are self-contained on the campus, including school classes. At Cheltenham, the same policies and procedures applicable to the secure portion of the facility were also applicable to the ReDirect program. Operations between the secure detention facility and ReDirect were fluid – direct care, professional, and teaching staff moved back and forth between the programs inside and outside the security fence. Staffing patterns and schedules for ReDirect were approved by the Cheltenham Superintendent, and staff from the secure detention center were assigned to cover shifts at ReDirect as needed. Teachers in the ReDirect and Shelter programs were considered part of the teaching corps of the Cheltenham School. A Cheltenham Assistant Superintendent was assigned to oversee the ReDirect program. Cheltenham's Security Detail was responsible for conducting checks at ReDirect/Murphy Cottage as well as the secure parts of the facility.

Following Ms. Wheeling's death, both the ReDirect Program and the shelter were closed although the Department of Juvenile Services has rekeyed Murphy Cottage and is exploring retrofitting the building with additional security hardware for possible reopening in 2011.

This Special Report of the Juvenile Justice Monitoring Unit (JJMU) examines safety and security policies and procedures at Cheltenham and makes recommendations for improvement. The report discusses confusing policies and protocols, scarcity of security equipment, staff

[1] The youth was 13 years old at the time of Ms. Wheeling's death.

shortages, and fatigue among overworked staff that contributed to making the Cheltenham facility as a whole a dangerous environment at the time of Ms. Wheeling's death.

The Department of Juvenile Services has made and continues to make safety improvements at Cheltenham since Ms. Wheeling's death, but more changes are needed to ensure staff and youth safety.

Cheltenham and other secure DJS facilities can significantly enhance the safety and security of staff and youth by providing or installing more security hardware. Such hardware should include an adequate number of surveillance cameras to cover public space and radios and personal distress alarms for all staff members. Because many extra keys were distributed to staff over the years, the Department is planning to completely rekey the facility, an essential step in improving security at Cheltenham. In addition, hardware for personal distress alarms and comprehensive camera coverage should be incorporated into any new physical plant built at Cheltenham.

Security equipment has been installed at some DJS facilities over the past three years. Cheltenham has a fence security system with sensors and the Department has indicated that fence cameras will be installed when the budget allows. Internal surveillance cameras have been installed at both the Alfred D. Noyes Children's Center (Noyes) and the Thomas J. S. Waxter Children's Center (Waxter). Cheltenham has installed internal security cameras in the dining hall, the main hallway of the school (not in classrooms), and common areas of the housing units. Two DJS secure detention centers[2] have had personal distress alarms for staff for several years.

Although security equipment is available at DJS facilities, all staff still do not have basic, essential security equipment at their fingers. The Hickey School still lacks a sophisticated fence monitoring system as does the Victor Cullen Center. Staff at Hickey, Noyes, Victor Cullen, and Waxter do not have personal distress alarms, and Hickey staff experience recurring radio shortages. At Cheltenham, six months after Ms. Wheeling's death, staff do not have enough radios. The staff share radios even in situations in which they are working with youth in different areas of the housing units and are out of sight and hearing range of other staff.

A workplace violence prevention plan that includes providing staff with necessary security hardware and equipment can help prevent loss of life or serious injury. However new security hardware will require appropriation of funds dedicated for this purpose during lean fiscal times.

The Department estimates it would cost over $6 million to retrofit all DJS-owned facilities with state-of-the-art security systems. At Cheltenham alone, DJS estimates the recommendations in this report will cost approximately $1.6 million. If funds are not available in the coming fiscal year to upgrade all facility security hardware, the Juvenile Justice

[2] Lower Eastern Shore Children's Center and Western Maryland Children's Center

Monitoring Unit recommends that improvements be phased in, beginning with the two facilities most in need of security hardware – Cheltenham and Hickey. The first security hardware purchases should be radios and personal distress alarms, followed by additional security cameras.

In the final analysis, improving safety at DJS facilities is not about money. It is about choosing to make the safety of staff and youth the fundamental priority.

EXECUTIVE SUMMARY

On February 17, 2010, Hannah Wheeling, a teacher in the ReDirect program at Cheltenham Youth Facility, was killed. A youth in the program, 13 years old at the time, was charged in connection with Ms. Wheeling's death.

In addition to the criminal investigation, the Department of Labor, Licensing and Regulation, Maryland Occupational Safety and Health (MOSH) and DJS' Office of the Inspector General (OIG) investigated the circumstances surrounding her death.

On August 18, 2010, MOSH found the Department of Juvenile Services in violation of state law requiring employers to furnish a workplace free of recognized hazards likely to cause death or serious harm to employees. A citation was issued against the Department for violation of workplace safety standards.[3] On September 20, 2010, DJS responded to the MOSH citation with a letter documenting corrective actions taken in response to the citation.

On August 20, 2010, DJS publicly released its March 15, 2010 OIG Investigative Report which placed primary responsibility for safety violations on four DJS staff whom the report found violated well-established safety policies and protocols.[4]

This report of the Juvenile Justice Monitoring Unit concludes that policies related to youth supervision were unclear, and that basic security equipment was, and still is, lacking at Cheltenham. Fatigue among overworked staff continues to contribute to sub-optimal supervision of youth at Cheltenham although there is no evidence that fatigue contributed to lax supervision of youth on the day Ms. Wheeling died.

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[3] Department of Labor, Licensing and Regulation, Maryland Occupational Safety and Health, Citations and Notification of Penalty, Inspection 313965659, Worksheet, August 18, 2010.

[4] Two direct care staffers were fired and an administrator was demoted. Another administrator who was in ReDirect on the afternoon of Ms. Wheeling's death and a supervisor who was not present were both disciplined. The staff member who issued Ms. Wheeling a key to the ReDirect building was also disciplined. However, the DJS OIG report only discusses the four direct care staff and recommends discipline against them. It does not discuss reasons the Department held these three managerial staff accountable or why no other Departmental staff were held accountable. Department of Juvenile Services Office of Inspector General Investigatory Report, March 15, 2010.

DJS policy requires that direct care staff (Resident Advisors/RAs) maintain constant sight and sound supervision over youth. On February 17, 2010, at Ms. Wheeling's request, ReDirect staff sent a youth downstairs to work with her in her classroom. ReDirect staff did not provide a staff escort or ongoing RA supervision. This violated the "sight and sound" policy. The supervision policy was violated several times over the course of the afternoon as this youth and one other youth were allowed to remain in Ms. Wheeling's classroom without RA supervision.

Teachers at Cheltenham frequently worked with individual youth without direct care staff supervision. The "sight and sound" supervision policy was widely violated at Cheltenham when teachers conducted one-on-one instructional sessions with youth.

Cheltenham did not have a sound, facility-specific key control policy, and an unknown number of staff had (and may still have) keys that were not authorized by the general DJS policy. Staff were unclear about who should be issued restricted keys, and it was widely known that Ms. Wheeling had been issued keys to the Murphy Cottage building.

Cheltenham was short of security staff, and those assigned to security detail were often pulled to provide direct care coverage. Perimeter security checks were not systematically documented nor was the exterior of the ReDirect building regularly patrolled as required by policy.

Leadership should have been well-aware of these issues. Supervisors regularly approved the unit logs showing who entered and exited the building, and knew, or should have known, that regular perimeter security checks were inconsistent or incomplete.

Historic staffing shortages at Cheltenham meant that there were frequently not enough direct care staff to supervise one-on-one teacher/student sessions. Over time, the failure to supervise these sessions became part of the culture of the institution. Cheltenham's chronic staffing shortages have been documented since at least 2004, when the U.S. Department of Justice discussed them in the report of its initial investigation into civil rights violations at Cheltenham.[5] In the settlement agreement following a law suit filed under the Civil Rights of Institutionalized Persons Act (CRIPA), the State of Maryland agreed to properly staff Cheltenham. In 2008, CRIPA monitors found Cheltenham to have the minimum sufficient number of staff to operate the facility safely, and Cheltenham exited CRIPA oversight.

However, CRIPA monitors warned at that time that current staffing levels were minimally acceptable, and that more staff were needed. During the ensuing years, direct care staff coverage shortages at Cheltenham continued and staff worked significant overtime hours.

[5] U.S. Department of Justice Civil Rights Division, *Investigation of the Cheltenham Youth Facility in Cheltenham, Maryland, and the Charles H. Hickey, Jr. School in Baltimore, Maryland*, April 9, 2004, pg. 48. http://www.justice.gov/crt/split/documents/cheltenham_md.pdf

During JJMU's investigation, direct care staff throughout the facility consistently reported that they continue to be overworked and fatigued, and teachers interviewed in the summer of 2010 reported that direct care staff sometimes fall asleep during class. It is well-documented that overworked staff do not maintain the alertness and patience needed to appropriately control volatile youth facility environments.

DJS has made improvements at Cheltenham since Ms. Wheeling's death. The ReDirect program has been closed, and the DJS OIG report recommends a number of safety improvements before reopening the program. JJMU recommends that the building remain closed permanently for residential use because its architecture makes it impossible to safely supervise youth other than on the top floor (See Recommendations, p. 26).

Other improvements made by the Department include:

- Comprehensive unannounced security and key control audits are being performed at least once a month.
- Staff have been trained on safety and security protocols and key control.
- Professional staff, including teachers, have been trained on safety protocols.
- A more stringent sign in/sign out procedure has been implemented, requiring every staff member to sign in and sign out at the campus Gatehouse upon arrival.
- A new procedure requires Department Heads to ensure all staff have left the building for the day and check out via the Tour Office.
- A facility-specific key control policy has been adopted.
- DJS has requested grant funding for an additional 90 security cameras.

Although substantial improvements have been made at Cheltenham, and more improvements are expected with the recent arrival of a new Superintendent, there are still security and safety issues that must be addressed. A large campus with outdated buildings together with a continuing lack of basic security equipment, ongoing staffing shortages and forced overtime, all contribute to Cheltenham's security vulnerability. Recommendations to enhance security at Cheltenham are included at the end of this report.

KEY FINDINGS

Youth Supervision

1. ReDirect staff violated DJS policy by failing to maintain sight and sound supervision over youth and allowing youth to move without supervision.

Direct care staff, also referred to as Resident Advisors (RAs), supervise the youth in DJS facilities. RAs provide the first line of security at facilities by escorting youth to locations around the campus, supervising them in housing units and classrooms, and ensuring the safety of youth and of other professional staff members (e.g., mental health and medical staff and teachers). They are fully accountable for the youth under their supervision, and among other responsibilities, DJS policy requires that they:

- "Maintain…sight and sound supervision of assigned youth inside as well as outside the building at all times;
- Know…the exact number of youth assigned to the unit, as well as knowing the location of each youth assigned to the unit."[6]

According to the DJS OIG and MOSH investigations, on the afternoon of February 17, Ms. Wheeling asked ReDirect RAs to send a youth down to her classroom on the lower level of the building. The RAs sent the youth down the stairs to her classroom without a staff escort.[7] This action directly violated DJS policies requiring that all youth movement be directly supervised by direct care staff.[8]

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[6] DJS Policy & Procedure RF-02-06 (Youth Movement and Counts) and CYF's Facility Operating Procedures on Supervision and Movement (effective January 17, 2006).

Maryland Standards for Juvenile Detention Facilities 5.1.2.2.04 Security. Direct care staff shall regulate all youth movement from one location to another, including individual…movement.

Maryland Department of Juvenile Maryland Department of Juvenile Services Policy 7 Procedure RF-02-06, Youth Movement and Counts. (5) Youth will not be allowed to move freely without the direct supervision of a designated facility employee.

CYF Facility Operating Procedure, Supervision and Movement. Supervision of Youth in the Building. All staff are responsible for maintaining sight and sound supervision of assigned youth inside as well as outside the building at all times…Staff shall always position themselves where there will be maximum sight supervision and not be 'blind spots' in the coverage/supervision of youth.

[7] Department of Labor, Licensing and Regulation, Maryland Occupational Safety and Health, Citation and Notification of Penalty, Inspection 313965659, Citation 1, Items 1 and 2, August 18, 2010. Department of Juvenile Services Office of Inspector General Investigatory Report, March 15, 2010.

[8] Maryland Standards for Juvenile Detention Facilities 5.1.2.2.04 Security, supra..

Maryland Department of Juvenile Maryland Department of Juvenile Services Policy 7 Procedure RF-02-06, Youth Movement and Counts, supra.

At approximately 3:45 pm, RAs took youth downstairs to the game room directly across the hall from Ms. Wheeling's classroom. The RAs supervising youth in the game room violated DJS policies by allowing a youth to be in the classroom across the hall with a teacher without maintaining constant sight and sound supervision of him.

At approximately 4:00 pm, Ms. Wheeling came into the game room and asked for a youth volunteer to assist her in cleaning the blackboard. Staff sent a youth volunteer to her classroom where he stayed for approximately 10 minutes before returning to the game room. This action also violated the "sight and sound" supervision policy.

At approximately 5:00 p.m., a ReDirect staff member saw the youth who was later charged in connection with Ms. Wheeling's death by himself in the upstairs hallway. The staff member directed the youth to return downstairs but apparently allowed him to go downstairs without a staff escort. This action also violated the DJS policies cited above.

Following its investigation of the situation surrounding Ms. Wheeling's death, Maryland Occupational Safety and Health (MOSH) cited the Department of Juvenile Services for "serious" workplace safety violations for failing to post an RA in the classroom during Ms. Wheeling's meeting and allowing a youth to travel between floors of the building without a staff escort.[9]

2. DJS did not have a clear policy on supervision of one-on-one instructional sessions, and policies were not consistently communicated to staff.

Before Ms. Wheeling's death, youth frequently worked one-on-one with teachers both in the main educational building inside the CYF fence and in the ReDirect program outside the fence without direct care staff supervision. Teachers removed students from class for one-on-one instruction (also called "pull outs") for a variety of reasons - to administer assessment testing, provide additional academic assistance, or to comply with the provisions of an Individualized Education Plan (IEP).[10]

Despite the 2005 Facility Operating Procedure that required staff to be within "sight and sound" of youth at all times, neither DJS nor CYF had a written policy that specifically required RAs to be present when teachers worked one-on-one with a youth. The most applicable written policy was a January, 2005, CYF Facility Operating Procedure (FOP) pertaining to youth supervision and movement. The portion of the policy relevant to school operations said:

1. Staff will be posted inside the classroom and provide supervision during classroom instruction. Staff will provide supervision in a manner so as not to

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CYF Facility Operating Procedure, Supervision and Movement. Supervision of Youth in the Building, supra.

[9] Department of Labor, Licensing and Regulation, Maryland Occupational Safety and Health, Citation and Notification of Penalty, Inspection 313965659, Citation 1, Items 1 and 2, August 18, 2010.

[10] Youth with Special Education needs are entitled to a certain number of hours each week of special services under federal law. Depending on the educational needs of a particular youth, this may include some hours of one-on-one instruction.

disrupt the instruction being given by the teacher. A supervisor will be posted in the school to assist in monitoring activities.

2. Youth movement during school and accountability for the population shall be conducted in accordance with established guidelines.[11]

All teachers and RAs interviewed in Summer, 2010 said they had never received a written policy specifically requiring an RA presence when a teacher conducts a one-on-one session.

However, all of the teachers interviewed also said that, at some point, they had been orally instructed by school administrators to have an RA present when working individually with youth. Teachers said that in practice, due to staff shortages, there was often no RA available to supervise these sessions.

JJMU interviewed 8 randomly chosen RAs[12] and asked what training or instruction they had received regarding supervision of one-on-one sessions with teachers. Five said they had not received any training, including Entry Level Training, about supervising one-on-ones. One RA said he could not remember whether he received training, and 2 RAs said they did receive training on one-on-ones.

Four of the RAs interviewed said that their supervisor had never orally instructed them to ensure that one-on-ones were supervised. Three said a supervisor did instruct them to supervise one-on-ones, and one RA said that although a supervisor had not explicitly told her to supervise one-on-ones, it was "common sense" that an RA should do so.

The general consensus among the RAs interviewed was that one-on-ones were only supervised when there were enough RAs present to keep the classroom or unit in ratio,[13] and that no one would risk putting staffing out of ratio to supervise a pull out. Due to staff shortages, it was quite common to not have enough RAs to do both. One RA said that in ReDirect, RAs generally supervised one-on-ones by going back and forth between the classroom and game room on the lower level of the building or standing in the hallway between the two, periodically checking on students in both locations.

[11] Cheltenham Youth Facility Operating Procedure Number FOP-004, *Supervision and Movement*, pg.4.

[12] Two of the eight RAs had worked in the ReDirect Program.

[13] During waking hours, the ReDirect program required that one direct care staff be present for each ten youth (a 1:10 staff:youth ratio). The Cheltenham secure detention program required that once direct care staff be present to supervise each eight youth (a 1:8 staff:youth ratio).

3. As a result, teachers frequently worked one-on-one with students without RA supervision.

The absence of a written or consistently communicated or enforced policy on RA supervision of one-on-one sessions created an ambiguity that resulted in RAs and teachers developing their own practices. Teachers used a variety of ad hoc security measures or took no protective measures at all.

One teacher said that, in the years before Ms. Wheeling's death, she[14] observed other teachers conducting one-on-one sessions without an RA present almost every day. One teacher said he conducted pull outs without an RA present as frequently as six to eight times a day before Ms. Wheeling was killed. Another teacher stated that she conducted pull outs approximately three to four times a day without an RA present before Ms. Wheeling's death.

Some teachers said they ensured another teacher was nearby before conducting one-on-one sessions, and some said they tried to ensure that they were aware when another teacher was working alone with a youth in a particular classroom. One teacher said she worked one-on-one with a youth only during class time, never after school had ended for the day. Others, however, said they had not perceived working one-on-one to be a security risk and, as a teacher put it, "We became complacent" about security.

One teacher commented, "We knew it was a risk, and anyone who says they did not know isn't being truthful. But we all broke the rules. It was the only way to get our jobs done. There wasn't enough staff to do anything else."

While many RAs appeared to be unaware that they were *required* to supervise pull outs, they were aware of the potential danger in unsupervised pull out sessions. One RA said that she sometimes told teachers they should not conduct pull outs with a certain youth without an RA being present because the youth had a violent background or was agitated that day.

The MOSH investigative report found that, while DJS had developed policy and procedures to ensure employee safety that included accounting for resident movement, "there is widespread noncompliance with these rules."[15]

The culture that developed at Cheltenham in which RAs did not supervise individual instructional sessions was illustrated on the afternoon of Ms. Wheeling's death. According to staff witnesses, at around 4:00 pm, a Cheltenham administrator entered the ReDirect building. Witnesses said that the administrator went to the game room to play cards with the youth.

[14] To preserve anonymity of staff interviewed during the investigation, gender of interviewees has sometimes been changed, and so stated gender may not reflect the actual gender of the staff member interviewed.

[15] MOSH Report, supra.

While he was in the game room, one youth left to help Ms. Wheeling clean her blackboard, and the suspect youth was in Ms. Wheeling's classroom.

Neither youth had an RA escort. The administrator did not comment on the fact that two youth were unsupervised or instruct RAs to go to Ms. Wheeling's classroom. Following Ms. Wheeling's death, the administrator was suspended for 10 days while two subordinate employees were terminated.

After Ms. Wheeling's death and the closing of ReDirect, Cheltenham administrators dedicated two RA positions to the school inside the fence to supervise pull-outs. These were not new RA positions; rather, existing RAs in the housing units were assigned to assist in the school. Surprisingly, RAs interviewed said that, even after Ms. Wheeling's death, they did not receive a written policy requiring supervision of one-on-one's and received no specific instructions on how to reconcile policy conflicts if one-on-one supervision of an instructional session would put the general unit out of required staff:youth ratio.

Supervision of one-on-one sessions continues to be erratic. During a monitoring visit in July, Monitors observed a teacher working alone in a classroom with a youth. No RA was present, either in the classroom or outside the classroom in the hallway. The Monitors reported the situation to the school principal and to CYF administration. School and direct care staff interviewed said that RAs continue to be unavailable at times because fluctuations in population require them to prioritize filling in on the housing units.

Security Hardware and Equipment

1. Cheltenham lacked security cameras that are essential to ensuring safety.

Cameras cover only a small fraction of the 900 acre campus at CYF. In its 3rd Quarter, 2008 Report, JJMU recommended that cameras be installed throughout the facility.

> "The Department (DJS) must complete the installation of a digital camera security system (including hardware, wiring and visual terminal[s]) to ensure the perimeter fence, public areas of the school and residential cottages are covered by security cameras."[16]

In the 3rd Quarter, 2009 Report, JJMU reiterated the need for comprehensive camera coverage throughout CYF and stated that "[c]amera coverage should be extended to classrooms and the cafeteria."[17] CYF did add camera coverage in the cafeteria, but at the time of Ms. Wheeling's death in February, 2010, cameras had not been added to the classrooms as

[16] 3rd Quarter, 2008 Report of the Juvenile Justice Monitoring Unit, Cheltenham Youth Facility, pg. 6. http://www.oag.state.md.us/JJMU/Q3_08/Cheltenham%20Final.pdf

[17] 3rd Quarter, 2009 Report of the Juvenile Justice Monitoring Unit, Cheltenham Youth Facility, pg. 14. http://www.oag.state.md.us/JJMU/Q3_09/Cheltenham.pdf

recommended, and there were no security cameras at all in Murphy Cottage, the building housing the ReDirect program.

The Department installed 49 new internal cameras and a digital recording system at Cheltenham in 2009. Grant funding has been requested to add an additional 90 cameras, including cameras in the ReDirect building, at an approximate cost of $400,000. This funding request is pending.

2. Security cameras should have been installed in Murphy Cottage.

Typically, Impact programs for youth who do not pose a danger to themselves or others do not need security hardware such as stationary cameras. However, the need for cameras as a real-time safety device is apparent once one walks the halls of Murphy Cottage. The building has two floors. The stairs leading down to the lower level are extremely narrow, completely enclosed in concrete, and include turns, making constant eye contact with youth virtually impossible. Indeed, walking down the stairs to the lower level, one cannot help but note the cavernous design of the building. On the bottom level, the game room and the classroom where Ms. Wheeling died are directly across the hall from each other.

A door at the rear of the classroom leads to another hallway and another set of concrete stairs leading to the top level. A locked door leads from this hallway to the exterior of the building – it can only be opened or closed with facility keys. Ms. Wheeling's body was found outside near the exterior part of this doorway.

The design of the building poses a security risk for any staff member who finds herself alone with a youth, particularly on the lower level. Sound does not carry from this portion of the building to any other portion of the building. Security cameras should have been installed to protect staff and youth.

3. Staff members, including teachers, should be issued personal distress alarms.

Cheltenham does not have personal distress or man down alarms for either teachers or direct care staff. The Juvenile Justice Monitoring Unit has long recommended that personal distress alarms be issued to staff as a means of enhancing security.

In 2007, ten youth escaped from the Charles Hickey School after assaulting staff members, breaking their radios and telephones, taking their keys, and locking them in the housing unit. Staff had no means of notifying others of the escape, and by the time the escape was discovered, the youth had cut a hole through the security fence and escaped. In a subsequent report, JJMU recommended that "direct care staff on the unit should be supplied with distress alarm devices that can be activated quickly and safely."[18]

[18] Special Report, Charles H. Hickey School, "Recommendations," June 22, 2007, pg. 15. http://www.oag.state.md.us/JJMU/reports/Hickey%20Final.pdf

Following a large group disturbance at Victor Cullen in 2009 that resulted in serious injuries to staff and the escape of fourteen youth, JJMU issued a Special Report. That report recommended that "staff should have panic alarms."[19]

In JJMU's First-Quarter Report in 2010, we recommended that "[s]chool staff, counselors, social workers and direct care staff at CYF should…be given man-down distress alarms."[20]

Before Ms. Wheeling's death, two secure detention centers, Western Maryland Children's Center (WMCC) and Lower Eastern Shore Children's Center (LESCC), were supplying personal distress alarms for staff. However, WMCC and LESCC are the smallest DJS detention centers (24 beds each), and operations are conducted in relatively small buildings.

At large secure facilities such as the Baltimore City Juvenile Justice Center (BCJJC) and facilities with spacious grounds and open space between buildings such as the Charles H. Hickey, Jr., School, the Victor Cullen Center, and Cheltenham, staff do not have personal distress alarms, even though the programs have experienced serious escape and staff assault incidents.

According to DJS estimates, providing personal duress alarms at Cheltenham would cost approximately $400,000. Providing personal distress alarms at Hickey would cost approximately $250,000. At the very least, funds should be appropriated to purchase personal distress alarms at these two facilities immediately because of their challenging geographic and architectural layout. Distress alarm funding for other DJS facilities should follow as the budget allows.

4. Staff members, including teachers, should have radios.

There are an insufficient number of radios at Cheltenham and Hickey for each RA or direct care staff to have a radio, and staff must share them. Teachers and most other professional staff do not have radios at all. This creates a safety issue as direct care staff attempt to strategically allocate radios while moving youth around the campus.

During a visit to Cheltenham on July 21, 2010, Monitors observed five RAs supervising youth on Rennie Cottage with only two radios among them. The 36 youth were split into three groups in various parts of a large housing unit. Two groups were in the front of the housing unit, and one group was in the back. If a group disturbance or other incident began in any part of the building, RAs might not know their colleagues needed immediate assistance.

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[19] Special Report, Victor Cullen Center, July 20, 2009 at p. 11.
http://www.oag.state.md.us/JJMU/reports/VictorCullen_Escape_and_%20Response.pdf

[20] 1st Quarter, 2010 Report, Juvenile Justice Monitoring Unit, pg. 50.
http://www.oag.state.md.us/JJMU/reports/10_quarter1.pdf

One direct care staffer interviewed described an incident in the spring of 2010 when he was supervising a group of youth and did not have a radio. Two youth in the group began fighting, and, while he was trying to separate youth and prevent injury, he had to send another youth unaccompanied to the front of the housing unit to request assistance from other RAs who were out of earshot.

Radios dedicated to the school following Ms. Wheeling's death have been moved to the housing units to cover shortages. At the time this report was drafted, neither the principal nor any education administrator in the school had a radio. At a meeting held at the end of September to discuss this report, DJS indicated that they had ensured four radios were available for use by school staff.

Currently, Cheltenham has a total of 54 radios available for staff use. DJS maintains that this is a sufficient number of radios for all direct care staff to have a radio. However staff continue to complain about radio shortages, and Monitors continue to observe staff sharing radios. By way of comparison, Lower Eastern Shore Children's Center with an average daily population of 25 (Cheltenham's average daily population is 116), has 41 radios for staff use. Even the Hickey School which experiences radio shortages has 56 radios for staff use (with an average daily population of 82).

DJS must purchase enough new radios for each staff member at Cheltenham to have one. This is a critical need.

Key Control, Sign-in/Sign-out Procedures, and Perimeter Security Checks

1. Cheltenham had no facility specific key control policy and staff lacked clarity about who should receive restricted keys.

At secure detention centers such as CYF, key control (procedures regarding the possession and use of keys to secure areas) is a major aspect of security. Strict accountability for each key in the facility is a central tenet of key control policies, and only certain employees have the ability to unilaterally access various buildings on the campus.

At the time of Ms. Wheeling's death, CYF did not have a facility-specific key control policy but operated under DJS's general policy. DJS's general key control policy is so general as to be vague and leaves many practical questions unanswered.

The DJS key control policy[21] does not specify which types of keys teachers can obtain. It leaves all discretion to the Facility Administrator to determine which keys should be classified as "restricted" and "highly restricted."[22] The policy also gives authority to the Facility

[21] DJS Policy RF-06-05 (January 25, 2006).

[22] Ibid. The policy defines "Highly Restricted Keys" and "Restricted Keys" as follows: "Highly Restricted Keys" means keys that provide access to highly sensitive areas and are issued only to authorized employees, as designated by the Facility

Administrator or manager on duty to "approve issuance of a restricted key to an employee not on the list of approved employees."[23] The policy does not include language regarding which areas of a facility should be accessed via regular vs. "restricted" vs. "highly restricted" keys.

The dearth of specific guidance on key control appears to have led to staff confusion about who should be granted restricted keys and ultimately an environment in which access to keys was not carefully controlled.

Normally teachers at Cheltenham do not have keys to buildings. However, teachers interviewed said that some years before her death, Ms. Wheeling was locked inside the ReDirect building for nearly two hours. Following this incident, on December 15, 2008, Ms. Wheeling completed a key request form and a staff member issued her keys to the ReDirect building. This gave her the ability to enter and exit the ReDirect building without the knowledge of other staff.

The employee who issued the keys said that the ex-school principal gave oral permission for Ms. Wheeling to have a key to the ReDirect building, but the OIG report on Ms. Wheeling's death found that oral approval was insufficient, that the Facility Administrator's permission was not given, and that the employee who issued the keys should be disciplined.[24]

The OIG report's conclusion – that responsibility lay with a single employee - is questionable. DJS had been warned at least twice between 2006 and 2010 about serious key control issues at Cheltenham and did not take action to inventory keys, change key barrels, or institute a clear policy.

In 2006, the CRIPA Monitor found Cheltenham to be in compliance with key control requirements of the settlement agreement, but "strongly recommended that the procedures for key control at CYF be enhanced to improve the level of security surrounding the issuing and return of keys."[25]

Three years later, in May 2009, a DJS Quality Improvement Report gave Cheltenham a "partial performance" rating on its key control system and concluded that Cheltenham was not following DJS' Key Control Policy. Specifically, CYF was not inventorying its keys pursuant to the policy. Moreover, the report expressed concern that "there may actually be missing keys they (CYF administrators) do not know about due to not inventorying them according to policy."[26]

Administrator. "Restricted Keys" means the keys grouped separately from regularly issued keys that may be issued to designated persons only.

[23] Ibid.

[24] Ibid.

[25] Third Monitors' Report for the Cheltenham Youth Facility and Charles H. Hickey School for the Period July 1 – December 31, 2006, p.42. http://www.djs.state.md.us/pdf/cripa-third-semi-annual-report-01-08-07.pdf.

[26] Maryland Department of Juvenile Services Office of Quality Improvement: Comprehensive Quality Review Report for Cheltenham Youth Facility, May 1, 2009 at pp. 31-21. http://www.djs.state.md.us/quality-assurance/qir-cheltenham.pdf

The Quality Improvement Report focused on the secure detention portion of the Cheltenham campus and not the ReDirect building, but all keys, including those to the ReDirect building, are distributed from an office in the secure portion of the campus.

Since Ms. Wheeling's death Cheltenham has been conducting a comprehensive key control audit on a monthly basis. These audits ensure that all keys are accounted for and are being distributed appropriately in compliance with policy.

Ultimately, however, it is impossible to account for keys that have been duplicated or traded among staff over the years. In addition to continuing the monthly key audits, DJS should replace all key barrels and issue new keys to all employees. At a late September meeting, DJS said that it has received an estimate and is planning to completely rekey the Cheltenham facility.

Prior to a late-September meeting, DJS administrators said they were working on a facility-specific key control policy for Cheltenham, and that the policy was in draft form. At the meeting the Department produced a copy of a policy which had an effective date of March 3, 2010, and was not marked as a draft (Cheltenham Facility Operating policy – 032). The policy is more detailed than the DJS's general policy that Cheltenham was following at the time of Ms. Wheeling's death. It is unclear when the new facility key control policy was adopted.

2. Staff did not sign in and out of the ReDirect building as required by DJS policy.

One of the MOSH citations issued against DJS was for failure to comply with Departmental policy FR-05-06, which requires that staff enter into the unit log all persons entering and exiting the building.[27] Review of ReDirect unit log books showed that teachers and other visitors regularly entered and exited the building without a notation being made in the logbook.

MOSH also found that the Cheltenham administration was aware of the practice because it "occurs regularly" and some of the logbook entries were approved by Supervisors (who are required to review and approve log books). "[S]upervisors…should have noticed the (failure to document) the entry into the unit of...teachers."[28]

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[27] Department of Juvenile Services Policy, General Documentation of Log Books, RF-05-06 (effective August 28, 2006). Department of Labor, Licensing and Regulation, Maryland Occupational Safety and Health, Citation and Notification of Penalty, Inspection 313965659, Worksheet, August 18, 2010.

[28] Ibid.

3. Security staff did not document perimeter security checks as required, nor did they perform security checks around the ReDirect Building (Murphy Cottage).

Cheltenham's Facility Operating Procedure required the Security Detail to conduct a visual inspection of the perimeter of the facility, including the exterior of Murphy Cottage at least once each shift and at first light each morning. The policy also required Security to complete a Perimeter Checklist/Log of the Security tour.[29]

In its May, 2009 report, DJS's Office of Quality Improvement gave the facility a "satisfactory performance" rating on security checks, finding that logs and Guard Tour electronic records[30] showed that most campus security checks were made as required. However, the report recommended that a checklist be developed to ensure that Security staff checked the same areas on each tour. A checklist already existed[31] but JJMU could find no evidence that Security staff completed the checklist either before or after the Quality Improvement Report recommendation, nor was there any evidence to show that Murphy Cottage was a regular part of the Security tour.

On several occasions, including in a written document request in March 2010, JJMU requested copies of checklists and/or perimeter security logs that would demonstrate whether ReDirect/Murphy Cottage was regularly checked during perimeter patrols. As of early September, 2010, DJS had not provided completed perimeter security check sheets as requested. In late September, 2010, shortly before this report was issued, DJS produced copies of completed perimeter security logs dating from March, 2010 that included checks of the ReDirect building.

Cheltenham administrators were unable to produce perimeter security checklists/logs for any date before February 17, the date of Ms. Wheeling's death. The conclusion drawn by JJMU is that completed checklists or logs likely do not exist or were not being kept as required by policy at the time of Ms. Wheeling's death.

Staffing

1. Cheltenham is significantly understaffed.

Cheltenham has suffered from staff coverage shortages for years. In April 2004, the U.S. Department of Justice (DOJ) Civil Rights Division observed that CYF was inadequately staffed

[29] Cheltenham Facility Operating Procedure Perimeter Security (effective January 12, 2005)

[30] Guard Tour is an electronic system that logs security rounds. Magnetic strips or conductors are installed at certain checkpoints, and the security staff uses a wand to show when s/he arrived at that checkpoint. The system keeps electronic records of security rounds and checkpoints.

[31] See Cheltenham Facility Operating Procedure Perimeter Security, Attachment A (effective January 12, 2005).

when it released a letter of its findings of violations of youth's civil rights at Cheltenham and the Charles H. Hickey, Jr. School under the Civil Rights of Institutionalized Persons Act (CRIPA).[32]

The U.S. Department of Justice recommended that DJS take immediate action to "ensure that there is sufficient, adequately trained staff to safely supervise youth."[33] In the Settlement Agreement, the State of Maryland agreed to "employ sufficient numbers of adequately trained… staff to supervise youth safely [and] protect youth from harm." As part of the Settlement Agreement, signed in 2005, the State of Maryland also agreed to submit to independent monitoring at both facilities to evaluate compliance with the Settlement Agreement.[34]

The federal monitoring and oversight of Cheltenham and Hickey ended in June of 2008 after CRIPA Monitors concluded that DJS was fully compliant with the Settlement Agreement and that Cheltenham and Hickey were sufficiently staffed. The CRIPA Monitors' Final Report, however, cautioned that while staff-youth ratios were within the range to protect youth from harm:

> These ratios should be considered minimal staffing ratios – they are sufficient only to the extent that the population congregates in only a few locations (e.g., dining hall, housing units). Given the convoluted physical design of the housing units…additional staff may be needed to adequately supervise youth.[35]

The MOSH investigative report found that "teachers were left alone with residents. This would likely occur when there were not enough Resident Advisors on duty to meet the…ratio of residents to Resident Advisors. This condition has existed as far back as 2003 according to (a U.S. Department of Justice) report…on the facility."[36]

JJMU reviewed Cheltenham operations, staffing schedules, and staffing logs both inside and outside the security fence at CYF to determine whether staffing shortages were either episodic or specific to the ReDirect program. This examination led to the conclusion that shift coverage shortages, and resulting use of overtime to cover shifts, was pervasive throughout the

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[32] 42 USC §1997. The State of Maryland and the U.S. Department of Justice entered into a Settlement Agreement on June 29, 2005. As a part of that Settlement Agreement, the State did not admit violating the federal rights of the juveniles detained at CYF or Hickey but expressed a commitment to enhancing conditions at the facilities.

[33] U.S. Department of Justice Civil Rights Division, *Investigation of the Cheltenham Youth Facility in Cheltenham, Maryland, and the Charles H. Hickey, Jr. School in Baltimore, Maryland*, April 9, 2004, pg. 48. http://www.justice.gov/crt/split/documents/cheltenham_md.pdf

[34] United States v. Maryland (Rule 41 Settlement Agreement concerning the Cheltenham and Hickey Youth Facilities), p. 7 (June 29, 2005). http://www.justice.gov/crt/split/documents/split_maryland_agree_6-29-05.pdf

[35] Sixth Monitors' Report on Cheltenham Youth Facility and Charles H. Hickey, Jr. School, p. 36 (June 30, 2008) http://djs.state.md.us/pdf/cripa-sixth-semi-annual-report.pdf

[36] Department of Labor, Licensing and Regulation, Maryland Occupational Safety and Health, Citation and Notification of Penalty, Inspection 313965659, Worksheet, August 18, 2010.

entire Cheltenham facility before Ms. Wheeling's death and continued up to the time of writing this report.[37]

2. Chronic staffing shortages led to employees working extensive overtime hours.

Staff shortages or shift coverage issues led to RAs at CYF working significant overtime hours. For the two-week pay period ending February 9, 2010 (8 days before Ms. Wheeling was killed), CYF employees logged 2920 overtime hours.[38] Assuming that overtime hours were evenly divided among staff, this is approximately 26 hours of overtime per employee in the two week period.

Based on self-reporting from direct care staff, however, overtime hours are not equally divided among RAs. Some RAs work more overtime than others – among RAs interviewed during the summer of 2010, some said they worked over 40 and others over 50 overtime hours regularly within a two-week pay period.

On February 17, two of the three RAs on duty in the ReDirect program were working their second consecutive shift although one was off for the two days prior and one had been off for the weekend prior. One of the RAs who was later terminated worked 32 straight hours (4 shifts) on Feb. 9 and 10.[39] The security detail staff member who was disciplined following Ms. Wheeling's death worked four double shifts on four consecutive days in January.[40]

These were not isolated examples of overtime. Many ReDirect staff regularly worked double shifts. Between January 22 and 24, 2010, one ReDirect RA worked from 6:00 am to 10:00 pm for three consecutive days. Another ReDirect RA worked a double shift starting at 10:00 pm January 18 and ending at 2:00 pm the next day, January 19, 2010. That same RA had an eight hour break and then worked the 10:00 pm to 6:00 am shift January 19-20, 2010. Another RA worked from 6:00 am to 10:00 pm for four consecutive days between February 4, 2010 and February 7, 2010.[41]

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[37] A major blizzard in February 2010 disrupted CYF's operations – the height of the snow storm was between February 5, 2010 and February 12, 2010. Understandably, a 100 year weather event disrupted staffing. However, the snowstorm does not explain the significant staffing shortages Cheltenham has experienced on-and-off for several years. The snow storm exacerbated existing staffing problems for approximately 10 days. By the time of Ms. Wheeling's death on February 17, staffing patterns had returned to normal, but significant amounts of snow remained on the ground.

[38] Department of Juvenile Services StateStat Report for February 26, 2010.
http://www.statestat.maryland.gov/reports/20100226%20DJS%20Template.pdf
StateStat is a performance-measurement tool implemented by Gov. Martin O'Malley that compiles statistical data from various statewide governmental agencies. StateStat reports are available to the public at www.statestat.maryland.gov.

[39] From 2:00 pm, February 9 until 10:00 pm, February 10. Source: Cheltenham Tour Office Log.

[40] Source: Cheltenham Tour Office Log.

[41] Source: Cheltenham Tour Office Log, Staffing Schedules for ReDirect, Henry Cottage, and Security Detail. Published staff schedules were compared to the Tour Office Log to determine which staff were scheduled and which actually worked shifts.

Staff coverage shortages and forced overtime work have been an issue at Cheltenham for years. In the Settlement Agreement with the U.S. Department of Justice, DJS agreed to take the necessary steps to provide a sufficient number of adequately trained staff. In 2006, the Third CRIPA Monitors' Report said:

> Staff reported working double shifts from two to as many as four times per week which takes an obvious toll on energy, patience, decision-making skills, and their ability to react appropriately when incidents occur…(S)taff reported that they are held over at least once every week—one staff reported serving 5 double shifts over the course of 7 days. Staff at both facilities [Cheltenham and Hickey] report they do not have enough staff, are worn out from working so much, and several indicated frustration with having "no life."[42]

In its 1st Quarter, 2008 Report, the Juvenile Justice Monitoring Unit reported that staff were physically and mentally exhausted from working overtime hours and cautioned that they could not properly protect youth safety and security under these working conditions.[43]

Following Ms. Wheeling's death, Cheltenham staff continued to work significant overtime hours. Between April 6 and July 27, 2010, staff logged an average of 2,880 hours of overtime during each two week pay period, 25 overtime hours per employee per pay period. Some employees report that they continue to work 40 or more overtime hours per pay period.

There is no evidence that staff fatigue led to the failure to supervise youth on the day of Ms. Wheeling's death, but forced overtime and fatigue continue to pose a safety and security challenge at the facility.

3. Chronic staffing shortages result in high "callout" hours, exacerbating overtime and staffing shortages.

JJMU's 2009 Annual Report explained that "there is a shortage of direct care staff for shift work (at Cheltenham). This is due, in part, to staff on sick leave and…staff calling in at the last minute to say they will not be able to come to work ('call-outs')…(S)taff call-outs and staff failure to…report for assigned shifts contribute to the overtime problem."[44]

Between July 1, 2008 and December 30, 2008, staff called out a total of 9,272 hours at Cheltenham, second only to the Baltimore City Juvenile Justice Center (BCJJC) in the number of

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[42] Third Monitors' Report for the Cheltenham Youth Facility and Charles H. Hickey School for the Period July 1 – December 31, 2006 at pp 39-40. http://www.djs.state.md.us/pdf/cripa-third-semi-annual-report-01-08-07.pdf.

[43] 1st Quarter, 2008 Report of the Juvenile Justice Monitoring Unit, Cheltenham Youth Facility, p. 4. www.oag.state.md.us/JJMU/Comp_0108_0308/Cheltenham%20Final.pdf

[44] 2009 Annual Report of the Juvenile Justice Monitoring Unit, p. 23 http://www.oag.state.md.us/JJMU/reports/2009_Annual_Report_Compilation.pdf

staff callout hours.[45] The callout problem at Cheltenham worsened significantly in the year before Ms. Wheeling's death. Between June 30, 2009 and December 29, 2009 CYF led all DJS facilities in callout hours with 12,368 total callout hours, a 33% increase over the same six month period in 2008. During this time period, callout hours averaged 883 per two week pay period.[46]

In the past few months, callout hours have declined from 2009 levels, averaging 786 hours for each two week period between April 6 and July 27, 2010. However, call out hours at Cheltenham still surpass 2008 levels by 19%.[47]

Staff interviewed explained that they call out because they are exhausted or concerned they will get stuck on duty once they report to work. One RA said that after working 16 straight hours, he often had only eight hours before his next shift began, and he occasionally overslept. Another said she calls out if her child has a school or medical appointment because she knows if she reports for her assigned shift, she may be held over for another shift.

Cheltenham has a policy on drafting employees for mandatory overtime, but the vast majority of staff said that most of the overtime they worked in any given pay period was mandatory rather than voluntary. They had no choice but to work the overtime or face disciplinary action.

The long hours and the unreliability of the published work schedules have resulted in a low morale among the direct care staff at Cheltenham. In turn, this has immediate implications for the youth who are under their supervision.

4. Chronic staffing shortages and overtime work led to staff fatigue and created an unsafe environment for staff and youth.

The danger inherent in operating workplaces with fatigued staff is well-documented. As the CRIPA Monitors described it, staffing shortages and forced overtime have "serious consequences for the quality of supervision, engagement of youth, and the ability to protect youth and staff from harm."[48] The May, 2009, report of DJS internal Quality Improvement Office also warned that "[d]ouble shifts lead to staff that are not as alert or patient as they need to be when working with a volatile population."[49] Many CYF teachers told us that before

[45] Department of Juvenile Services StateStat Reports, July 1 through December 30, 2008.

[46] Department of Juvenile Services StateStat Reports, June 30 through December 29, 2009.

[47] Department of Juvenile Services StateStat Reports, April 6 through July 27, 2010 and July 1 – December 30, 2008.

[48] Third Monitors' Report for the Cheltenham Youth Facility and Charles H. Hickey, Jr. School, for the period January 1 – June 30, 2006.

[49] Md. Department of Juvenile Services Office of Quality Improvement: Comprehensive Quality Review Report for Cheltenham Youth Facility, May 1, 2009. http://www.djs.state.md.us/quality-assurance/qir-cheltenham.pdf

Ms. Wheeling was killed, it was common for the RAs to fall asleep during classes and when they were supposed to be monitoring the youth. When we interviewed teachers in June and July, they reported that RAs continue to fall asleep in class. Many of the RAs confirmed that forced overtime has not improved much since Ms. Wheeling's death, and that they continue to be exhausted and fatigued, particularly when they are on an overtime or double shift.

One encouraging note is that overtime hours and callout hours at Cheltenham have dropped by almost 10% in the four months preceding the release of this report. While staff continue to complain about being overworked, this is a move in the right direction.

5. Cheltenham suffers from chronic *security staffing* shortages, creating an unsafe environment for staff and youth.

CYF's security detail also logged a significant number of overtime hours between January 18, 2010 and February 17, 2010. The security detail at CYF is tasked with checking the perimeter fence at the facility and performing various campus-wide security functions. Typically, no more than two RAs per shift are assigned to this detail. One employee assigned to the security detail worked from 2:00 pm to 6:00 am, or 16 straight hours, on four consecutive days between January 20 and January 24, 2010. Another security employee worked from 6:00 am to 10:00 pm on five consecutive days between January 23 and January 27, 2010. On February 7, 2010, another staff member worked the security detail for a consecutive twenty-four hours.[50]

In addition to working a significant number of consecutive hours, the members of the security detail were often reassigned to another unit in the middle of their shift to provide staffing on one of the units, leaving the facility without security staff. For example, on January 19, 2010,[51] both of the staff members assigned to the security detail were pulled and moved to Henry Cottage to cover staff shortages, leaving the facility with no dedicated Security staff.

At times, the security detail was left vacant for an entire shift. For example, on February 6-7, during the overnight shift, and during the 6:00 am – 2:00 pm shift on February 7, there were no staff to work security.

On the day of Ms. Wheeling's death, the security detail was not staffed for the 5 a.m. to 1 p.m. shift.[52] The inability of a secure detention center to staff its security detail suggests significant personnel issues that should have been addressed. Based on conversations with staff at CYF and our first-hand observations following Ms. Wheeling's death, DJS has yet to adequately address these issues.

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[50] Source: Cheltenham Tour Office Log and Staffing Schedules.

[51] 6:00 am to 2:00 pm shift.

[52] Source: Cheltenham Tour Office Log.

Additional staff positions must be allocated to Cheltenham and filled to reduce mandatory overtime and callouts. This is a critical priority.

5. DJS OIG Report and Corrective Actions

Among other duties, JJMU is legislatively tasked with evaluating the Department of Juvenile Services internal monitoring process, including investigations and reports produced by the DJS Office of Inspector General (OIG).[53]

A draft DJS OIG report on circumstances surrounding Ms. Wheeling's Death was issued on March 15, and on August 20, an expanded interim version of the DJS OIG report was publicly released. This report provided a basis for disciplining staff, including the termination of two direct care workers and the disciplining of both a security staff member on duty the night of Ms. Wheeling's death and the staff member who issued ReDirect building keys to Ms. Wheeling.[54]

Although at least three other staff were disciplined following the incident, their actions or the fact they were recommended for discipline was not discussed in the OIG report. These include a current and former senior administrator at Cheltenham and a direct care worker supervisor (who was not working on the day Ms. Wheeling died).

On the positive side (and also unlike most DJS OIG reports), this OIG report includes recommendations for improving safety and security. Unfortunately, the recommendations are limited to the ReDirect program and do not extend to the entirety of the Cheltenham campus or to other DJS facilities with security challenges. The OIG report recommendations also mirror steps already taken by the Department before the August 20 release date of the report. Particularly following an incident resulting in loss of life, a more complete report from the Department and its Office of Inspector General should be issued. JJMU recommends that the final OIG report include recommendations for improving safety and security at all DJS facilities.

CONCLUSION

Hannah Wheeling's death was a tragic event resulting from multiple systemic security failures at Cheltenham. Some responsibility for her death must be placed on Cheltenham's outdated buildings and a compromised security culture. Responsibility must also be placed on the departmental leadership that should have addressed these issues.

[53] Md. State Govt. Article, §§6-401 to 6-406.

[54] Department of Juvenile Services Office of Inspector General, Investigatory Report, March 15, 2010.

Positive changes have been made at Cheltenham to enhance security since Ms. Wheeling's death. Security hardware, including cameras and vision kits are planned for installation in the ReDirect building, if and when the building is re-opened. The Department has plans to rekey the entire facility. Frequent comprehensive key[55] and security audits are being conducted. Staff are being retrained on security procedures, including key control.

And many positive security enhancements have been made at other DJS facilities, including installation of vision kits and cameras. But few security hardware additions have been made to the secure detention portion of the Cheltenham campus and this must be a priority.

Cheltenham continues to suffer from staffing shortages and resulting fatigue among staff and radios continue to be in short supply. Personal distress alarms should be purchased immediately. Other DJS facilities already have them, while staff at large campuses such as Cheltenham, Hickey and the Victor Cullen Center are most in need of such devices. In addition, ongoing secure systematic key control is complicated by the likelihood that keys have been lost or duplicated over the years. The key barrels need to be replaced and an expert charged with key control. The Department's plan to rekey the facility is a positive step.

[55] Key audits are conducted by examining staff key rings to determine whether they have appropriate keys, interviewing staff to determine their level of understanding of the key control policy, and reviewing relevant documentation.

RECOMMENDATIONS

Short Term

1. Cheltenham administration should clarify the sight and sound supervision policy, and should instruct all staff on rules regarding one-on-one supervision.

2. Sufficient radios should be purchased immediately for staff to ensure that each staff member on each shift has a radio.

3. Personal distress alarms should be purchased immediately for all staff. If the current budget is inadequate, personal distress alarms should at least be provided for staff at Hickey and Cheltenham.

4. The entire Cheltenham campus, not just the ReDirect building, should be retrofitted with additional security cameras and windows inserted into office doors to allow visual supervision of youth in confidential one-on-one sessions.

5. All old buildings in the DJS inventory should be similarly retrofitted.

6. One-on-one teacher-youth sessions/pull-outs at Cheltenham should not occur unless there are sufficient direct care staff to supervise them.

7. The Department should move forward with its plans to rekey the Cheltenham campus and continue monthly key control audits.

8. Each DJS facility should develop its own expertly developed facility-specific Key Control Policy.

9. Additional school staff with crisis prevention and education training should be hired as Instructional Assistants in the school to supervise one-on-one instruction and should report directly to the school administration as they do at other facilities to avoid staff being pulled to cover housing unit staff shortages. This would alleviate the need for housing staff to supervise youth in the school and be consistent with the dedicated school staff model practice at MSDE-operated schools in DJS facilities.

Long Term

1. More staff must be hired at Cheltenham and Hickey where the RA vacancy rates are 27% and 17% respectively, and at Noyes (47% vacancy rate) and Waxter (31% vacancy rate).

2. Mandatory overtime must be significantly reduced, and this can only occur with the addition of new staff.

3. Compensation rates and required qualifications for new direct care staff should be raised to facilitate full professionalization of the DJS workforce. DJS spent over $7.5 million in overtime pay in 2009, over $2 million at Cheltenham alone. This money can be used more effectively to increase pay and hire new staff.

4. Murphy Cottage should not be reopened as a residential program. While the building could be retrofitted to make it somewhat safer, the design is not appropriate for supervision of youth.

5. Staff should be assigned to view screens with real-time camera feeds from throughout the Cheltenham facility. This is the only way that security cameras function as a real-time security device. At BCJJC, one to two employees work full-time in the Master Control Office and monitor camera feeds at all times.

6. Personal distress alarms should be included in the planning of all planned DJS detention and treatment facilities in the future. Staff at all facilities, including all professional staff, should be given distress alarms as soon as funding becomes available.

APPENDIX A

EVIDENTIARY BASIS FOR REPORT

- ReDirect Unit Log Book
- Cheltenham Master Control Log Book
- Maryland State Governor's Office StateStat Reports, Department of Juvenile Services (October, 2008 through May, 2010)
- Department of Juvenile Services Office of the Inspector General Draft Report on Cheltenham Youth Facility: ReDirect Building, Peter J. Keefer (March 15, 2010)
- Cheltenham Facility Operating Procedure, Supervision and Movement (effective date, January 12, 2005)
- Cheltenham Facility Operating Procedure, Perimeter Security (effective date, January 12, 2005)
- Cheltenham Facility Operating Procedure, Physical Count Procedures (effective date, January 17, 2006)
- Cheltenham Facility Operating Procedure, Draft Procedures for Mandatory Overtime (effective date, January 16, 2008)
- Cheltenham Daily Security Perimeter Checklist
- Memorandum from Reginald Garnett, Superintendent, "Signing In/Out" (June 11, 2007)
- Memorandum from Quanetta West, Superintendent, "Tour Guard" (November 10, 2008)
- Memorandum from Antonio Pauley, Sr., Assistant Superintendent, "Staff to Student Ratio" (March 16, 2009)
- Memorandum from Antonio Pauley, Sr., Assistant Superintendent, "CYF School Procedure" (July 15, 2009)
- Memorandum from Quanetta West, Superintendent, "Perimeter Checks of Re-Direct & Shelter Care Cottages" (February 19, 2010)

- Memorandum from Quanetta West, Superintendent, “Transportation of CYF Staff” (February 19, 2010)

- Memorandum from Antonio Pauley, Sr., Assistant Superintendent, “Prohibited Items and Searches-Directive #1” (March 5, 2010)

- Memorandum from Reginald Garnett, Assistant Secretary, “CORRECTION – New Procedure” (March 10, 2010)

- Department of Juvenile Services Incident Reports #83375 and #83550

APPENDIX B

APPLICABLE STANDARDS

General

Maryland Standards for Juvenile Detention Facilities 1.6 Policy and Procedure Manuals. Policies and procedures for operating and maintaining each detention facility shall be specified in a manual that is accessible to all employees. All employees shall be trained and shall be familiar with all policies that affect their work. This manual shall be reviewed annually and updated as needed.

Maryland Standards for Juvenile Detention Facilities 5.1.2.2. Security. Security refers to the provision of staff and resident safety and to the prevention of escape from the facility…Means to ensure security shall consist of physical features of the building and grounds, policy and procedures, and staffing arrangements.

Youth Supervision and Movement

Maryland Standards for Juvenile Detention Facilities 5.1.2.2.04 Security. Direct care staff shall regulate all youth movement from one location to another, including individual and group movement to and from all activities and programs according to written policies and procedures.

Maryland Department of Juvenile Services Policy & Procedure RF-02-06, Youth Movement and Counts (effective January 17, 2006). (4) Group movement of youth will be accomplished in an orderly fashion and under employee supervision. Accountability of the authorized whereabouts of each youth will be maintained as a component of movement. (5) Youth will not be allowed to move freely without the direct supervision of a designated facility employee.

Memorandum from Antonio Pauley, Sr., CYF School Procedure (July 15, 2009). While on duty the Hall Monitor and/or designee will adhere to the following procedures:

1) Conduct a thorough walk through prior to the start of school and immediately after school has ended. A report must be submitted to the Group Life Manager II, if you notice damage to equipment, graffiti and anything else deemed as unacceptable.

2) You will be responsible for all movement coming and going from the school.

3) Security checks must be conducted every 30 minutes in each classroom by the Security Supervisor.

4) Ensure the safety and security in all areas of the school and intervene when necessary.

5) […]Ensure that all Resident Advisors posted in the school are adhering to the protocol. In the event a Resident Advisor has failed to comply with the school procedures they

shall be further disciplined by the Security Supervisor in accordance with DJS Standards of Conduct.

CYF Facility Operating Procedure (Effective Date: Jan. 12, 2005): Supervision and Movement.

Supervision of Youth in the Building:

1. All staff are responsible for maintaining sight and sound supervision of assigned youth inside as well as outside the building at all times.

2. Staff shall not leave their assigned area of responsibility without first notifying and receiving approval from the Shift Commander.

3. Staff shall always position themselves where there will be maximum sight supervision and not be "blind spots" in the coverage/supervision of youth. When a staff is working on single coverage, maintenance of sight supervision may require assigning the group to a designated area of the day room for a limited period to provide for sight supervision of the group.

4. Staff shall always be responsible for knowing the exact number of youth assigned to the unit, as well as knowing the location of each youth assigned to the unit. The unit logbook shall be used to record the location of youth assigned to the unit who are away from the campus for any reason.

Key Control

Maryland Standards for Juvenile Detention Facilities 5.1.2.4.01 Key and Equipment Control. Written policy, procedure and practice shall govern the control and use of keys.

Department of Juvenile Services, Key Control Policy #RF-06-05 (Residential Facilities):

General Procedures (Duties and Responsibilities).

The Facility Administrator will:

(i) Designate a Key Control Officer to be responsible for the storage and inventory of all keys.

(ii) Identify keys that are restricted and highly restricted. At a minimum, keys to storage areas for health records will be highly restricted.

(iii) Approve all key making, duplication or change of any key, door, or lock.

The Key Control Officer will:

(i) Maintain a Working Key Board and a Back-up Key Board along with an inventory of all keys and keyboards.

(ii) Maintain a master count of all key blanks.

(iii) Randomly count the number of keys on one key ring each working day and document the count in the facility logbook.

(iv) Maintain an inventory of the Back-up Key Board.

(v) Monitor the facility logbook and any incident reports on a daily basis and correct any unresolved deficiencies regarding key control that are recorded in the logbook.

(vi) Test emergency keys quarterly to ensure proper function. Documentation shall be recorded on the ***Quarterly Emergency Key Inspection Form (Appendix 4)*.**

d. Issuance and Maintenance of Keys.

(5) No employee will possess, alter, mark, duplicate, manufacture, make impressions of keys, or add/remove keys from rings without authorization from the Facility Administrator or Chief of Maintenance.

Unit Log Books

Department of Juvenile Services, General Documentation of Log Books, Policy RF-05-06 (effective August 28, 2006). Employees are responsible for making log book entries relevant to, but not limited to, the following events… Any changes to the unit staffing that occur after the (beginning of the shift).

Perimeter Security Checks

CYF Facility Operating Procedure Perimeter Security (effective date, January 12, 2005) A visual inspection of the perimeter fence and areas directly within the perimeter at least once each shift and at first light each morning shall be conducted by Security Staff or designee. A Perimeter Checklist (Attachment 1*) must be completed by the staff conducting the inspection and reviewed by the Shift Commander. A copy shall be forwarded to the Asst. Superintendent for Operations for record.

*(Attachment 1): Cheltenham Youth Facility Daily Perimeter Checklist required that the Security detail check the perimeter of the Murphy Shelter, which housed ReDirect, as well as other buildings inside and outside of the security fence.

Staffing

Maryland Standards for Juvenile Detention Facilities 5.1.3 Staffing. Staffing arrangements shall aim to provide a safe, humane, and caring environment. Youth to staff ratios developed by the Department shall ensure adequate supervision of youth. The allocation, deployment and assignment of resources/personnel to each facility shall be based on: 1. the budgeted population operating capacity; 2. the level of risk and needs of the population; 3. facility programs and services; and 4. physical plant architecture. Staff to youth ratios shall not be

generalized, but rather based on facility design and age, activity and program level and other related factors.

Maryland Standards for Juvenile Detention Facilities 5.1.5.5 Staffing. Staffing levels shall ensure the proper supervision and safety of the residents.

Staff Overtime

CYF Facility Operating Procedure (Draft Procedures for Mandatory Overtime). All classifications of Direct Care Staff (Resident Advisors, Resident Advisor Supervisors and Supervisors of Group Life) are required to work mandatory overtime as needed by the facility to maintain coverage of critical posts. Direct Care Staff will be subject to the draft in a fair, equitable and consistent manner based on the following procedures.

Staff Subject to the Draft

1. All Resident Advisor Trainees and Resident Advisor I's, II's and III's are subject to the draft as defined in this procedure.
2. Resident Advisor Supervisors, if needed, shall provide coverage or maintain a post in the unit they manage.
3. All Supervisors of Group Living I's, if needed, shall be subject to draft to cover vacancies for each other.

Draft Guidelines

1. Staff will not be drafted on a rest day. If the staff has volunteered to work on a rest day, he/she will not be required to work an additional shift.
2. Staff who work a minimum of four consecutive hours beyond their scheduled shift will be credited with working a draft and will have earned the right for his/her name to be moved to the bottom of the Draft List
3. Staff who volunteer for overtime will not be credited with having worked a draft.
4. No staff will be required to work more than 16 consecutive hours except in an emergency.
5. Unless otherwise approved by the Superintendent or designee, staff will not work more than twenty-four (24) hours of overtime in a pay week.