

**MONITORS' ASSESSMENT OF FACILITIES AND THE  
DEPARTMENT OF JUVENILE SERVICES RESPONSE**

**January – March 2005**

The Cumberland YMCA on property that is owned by DJS operates the **Allegany County Girls Group Home (ACGGH)**. The program serves nine female residents, and features what it terms a “healthy home” model which involves a combination of group and individualized treatment. Community resources for education, health and counseling are utilized. Overall, the program has continued to evolve as staff are working better as a team.

ACGGH has made plans to undertake a number of upgrades on its own. For example, plans have been made to take down some trees near the building, and create an outdoor picnic and barbeque area. Also, a garden is being planned which will provide an opportunity for staff and residents to work together. Two picture windows in the front of the home will be replaced. The ceiling tiles in the basement are slated to be replaced, and some new appliances will be purchased. Also, new beds are reportedly going to be provided for the youth, and the pool table will be relined.

The basement door leading to the back of the house is still not equipped with an alert when it is opened, as was suggested by this writer after two girls left the facility without permission by simply walking through the door unknown to staff. While the facility is not designed to be physically secure, increased supervision is needed, and is being provided according to ACGGH administration. The issue of supervision has been raised previously as a need to be addressed. The program should also insure that structure, routine and order are maintained, and that the girls are dressed appropriately and supervised adequately when off grounds. Reportedly, these issues are also being addressed.

- **Unabated for 30 Days or More:** The property and grounds at the Allegany County Girls Group Home are generally kept in good shape. The road leading to the facility continues to be in a state of disrepair. The Department of Juvenile Services has indicated that the road will be resurfaced in the fall of this year. However, in the past, this project has been reportedly scheduled only to have it be put off once again. The road has been in bad shape for over two years at this point, and is long overdue for repair. Along with the surface repair, the trees lining the road should be removed so that the sun can dry out the surface after rain or snow. This will help provide for the longevity of the road.

**Response:**

This item is still on the list of maintenance repairs.

- Staff training led by psychologist Dr. Jim Miller occurs on a weekly basis. In addition to the mandatory trainings, the staff have focused on the issue of teamwork and providing consistency in the application of rules and structure.

Family dynamics has also been discussed. It has also been suggested that, when possible, staff training focus on group dynamics, and also on treatment issues that are gender specific in working with females. The Female Population Task Force meetings led by Marian Daniel meets on a monthly basis, and should be attended by at least one ACGGH staff. As of this writing no representative from ACGGH has attended this important group.

**Response:**

The Task Force has been invited to the Group Home for their June meeting.

- ACGGH has become better known and recognized as a viable resource for referrals from the Department. Occasionally the group home has accepted particularly challenging youth. Recently two girls had to be removed from the facility. Referrals are plentiful, however, and the beds are quickly being filled. One youth in particular had been aggressive to the point of having to call the police on numerous occasions, and additionally, was disruptive in school. Upon removal from the program for being noncompliant, DJS discharged this youth back to her home and the public school in her community. Further treatment and intensified services may have been in order given these circumstances.

**Response:**

No child should be discharged without services and it is important for the monitor not to make these allegations without having complete knowledge of the planning.

The **Youth Centers** are state owned programs that are operated by the Department of Juvenile Services. They are located in Allegany and Garrett Counties of Western Maryland. There are four Centers: **Green Ridge, Savage Mountain, Meadow Mountain, and Backbone Mountain.** Meadow Mountain operates specifically as an addictions program. The average length of stay in the programs is six months. A total population of 156 youth is served in the Youth Centers.

The Youth Centers have continued to improve programming and supervision. The youth participate in many and various activities on and off campus. The combination of education and treatment delivered in the Centers is good overall, especially given the limitation of time and resources available.

- The DJS budget shortfall will reportedly affect the Youth Centers by requiring that funding be cut by \$160,000. Fortunately, most of the staff positions that were vacant or taken from the Youth Centers have already been filled. This has helped the Youth Centers provide better supervision and programming. Other longstanding vacancies apparently will not be filled anytime soon. Meadow Mountain Youth Center, for example, has been without a Clinical Director for over a year, and there continues to be other vacancies as well.

**Response:**

There has been no decision made about not filling positions. The monitor should not make statements that cannot be substantiated.

- Also affected by lack of funding, is the aging equipment, particularly the vans that are essential to the Youth Centers. With the more mechanical breakdowns of the vans, not only are outings and activities affected, but safety could also be compromised if vans are not readily available for medical transportation or in the event that a Center would have to be evacuated.

**Response:**

It is true that the Youth Centers, like all other state agencies, would benefit from regular equipment upgrades and replacements, particularly in the area of vehicles. Our fleet is maintained to DOT standards, and problems are addressed and corrected as they arise. However, their age and mileage do impact the frequency with which they are out of service, and consequently affect program operation. Though our vans are up to 10 years old, only three (3) of the vans assigned to the Centers have over 100,000 miles on them, and only some of our transportation vehicles are over, or even near, the current 150,000 mile scheduled replacement mark. When a vehicle is in the shop for maintenance or repairs, there are always other vehicles available to deal with any emergencies that might arise in a Center, and in the event that a Center would need to be evacuated, vehicles would be borrowed from other Centers if necessary.

- The Centers have been working to enhance the teambuilding on each campus. This has been needed and could be of help in improving communication, trust, and problem resolution. One recommendation has been to place a suggestion box on each campus and at the Cumberland Youth Center Headquarters for staff, visitors or family members to submit concerns and/or ideas anonymously.

**Response:**

The Vo-Tech class at the Center will be constructing the recommended Suggestion Boxes.

- An issue of concern, especially with the budget cuts, is that there is no recreation fund for the youth in the Centers. Recreational activities are a vital part of the treatment process, and should be provided for in the budget. However, this is not the case, and the Centers have relied on the income from youth using the pay phones. In the contract with AT&T, 48 percent of the profit was returned to DJS. In the spring of 2004, however, this source of revenue was discontinued. DJS should actively pursue the issue with the phone company, and additionally, ensure that recreation is funded regardless of this funding source being reinstated.

**Response:**

Some time ago we realized that the recreation accounts of our Centers were no longer receiving any significant contributions from the collect telephone contracts. With some assistance from our IT office, we were able to determine that the reduction in the amount of commission generated by the Department's collect telephone contracts was the result of a new contract for that service having been negotiated by the Department of Budget and Management. The conditions of that contract are apparently outside the scope of influence of DJS' IT office, and from what we are told, not subject to change. For some reason, DBM approved a contract that provides a significantly lower commission on calls made from lines at DJS facilities than calls made from lines at DOC facilities. If there is any logical reason for them accepting such an arrangement, it is beyond my comprehension. In the meantime we have no budgeted funding for our youth activities.

- Youth would be better served to have the same Probation Officer/Community Case Manager throughout their contact with DJS, and be followed closely by that person through the process of treatment and positive integration into the community, including aftercare. Developing a positive relationship with a consistent and caring adult through time is a very important element of successfully serving youth.

**Response:**

While we appreciate the monitor's opinion about how we manage our resources, we will continue to manage our resources in a manner consistent with our vision and mission. We recognize the need for consistency and relationship development between the workers and the youth but we also recognize that maintaining the youth from intake to aftercare is not always the best use of resources.

- **Unabated for 30 Days or More:** Though there was a concerted effort in 2004 to develop Commitment Care Standards, including the involvement of the Office of the Independent Monitor, the committee was disbanded in the fall, and will reportedly not be reconvened until replacements are hired to fill policy unit vacancies. In the absence of official Commitment Care Standards, a Procedure Manual developed by the Youth Centers and by Secretary Directives guides the Youth Centers.

**Response:**

No response needed.

- With regard to supervision, the Youth Centers have made an effort to ensure that staffing coverage is more adequately provided on second shift and on weekends. This has been difficult in some cases because of the reluctance to pay overtime. Additionally, however, Case Managers and supervisory personnel, reportedly up to the level of the Center Supervisor, have been directed to be present more frequently in the Centers during these off hours. During the daytime hours, there

are sufficient numbers of staff, including teachers, supervisory, and administrative staff to provide programming in the Centers and ensure for safety and security. A concern, however, is that at times on second shift and on weekends, direct care staff that are not certified to be with youth in single coverage are in situations where they are alone in coverage. This should not occur as it presents a safety and a liability problem for the youth, for the staff, and for the Department. It is of concern that it takes so long, up to a year, for a new staff to receive his or her background clearance, and thus become fully certified to be in coverage without a shadow staff present.

**Response:**

For the record, there is no reluctance on behalf of the Youth Centers Administration to utilize overtime to provide necessary levels of supervision for youth in our program. We do however expect our Center Directors to utilize it judiciously and responsibly. Staff who have not attained at least provisional certification should not be utilized in coverage without a certified staff person in the vicinity, and if the monitor is aware of specific occasions where that has happened, and will provide us with that information, we will follow up appropriately. We fully concur with his concerns about the length of time required for staff to become certified, and make every effort to ensure that all possible steps are taken by our personnel office to facilitate the process.

- An issue that affects programming that has been raised numerous times is the process in which identified youth are removed from their groups in the other Centers and enrolled into the addictions program at Meadow Mountain. While the program at Meadow Mountain is a very viable program, the process of enrollment is very disruptive to the group process that is the basis for treatment in the other Centers. Youth going to Meadow Mountain are identified when they enter the Youth Centers, and then go to a group in one of the other Centers while awaiting a bed at Meadow Mountain. In order to have effective group process and a positive peer culture, it is necessary to have a developing group over a significant period of time. The Youth Centers program is very limited in time as the average length of stay is approximately 6-7months. The groups often stay at the beginning stages of group process because of the rapid turnover within the group. The process of moving youth into Meadow Mountain contributes to the turnover and limits the investment that youth have in one another, as it is known that at any time the identified youth will leave the group to enroll at Meadow Mountain. This is one issue that requires discussion as to how to better empower the groups, enhance the effectiveness of the positive peer culture group process program, and facilitate the enrollment of identified youth into the addictions program.

**Response:**

The monitor has repeatedly expressed his opinion on the process used by the Youth Centers to ensure that youth placed at the Meadow Mountain Intensive Outpatient program are appropriate for that program, and steadfastly refused to

acknowledge that there were circumstances that made it the best overall solution, in spite of its shortcomings. In recent weeks, due to some changes taking place in our Green Ridge program, including the initiation of an Intensive Outpatient treatment group, we have found it necessary to modify the previous Meadow Mountain intake process. From now on, youth will be selected for the Meadow Mountain program based on assessments done at detention programs and in their communities, and any other available information, and admitted directly to the Meadow Mountain program. In cases where the information available is inconclusive, youth will be admitted to our other Centers where a complete assessment can be done, and moved to the next available bed at Meadow Mountain should placement in that program be appropriate. We assume that the monitor will find the new process more to his liking.

- An issue of concern regarding education, and previously reported without remedy, is the practice of youth being referred and accepted into the Youth Centers whose special education needs surpass the ability of the Centers to provide. The Youth Centers have been directed not to reject a youth based on educational needs. Rather, they have been directed to hold an intake IEP meeting and then amend the document to reflect the services that can be provided. This is in violation of State and Federal requirements.

**Response:**

DJS complies with Federal and State Special Education requirements to convene multi-disciplinary team meetings to review IEPs from prior schools and to determine youths' current educational strengths and needs. In all cases, decisions of the multi-disciplinary teams regarding special education services should be based on the unique needs of each youth. IEP services are not changed to reflect services available.

DJS Education Superintendent met with Youth Centers Superintendent, Intake staff, and Special Education Coordinator to clarify the consideration of special education factors in admission decisions.

DJS Education Superintendent drafted language relevant to above discussion, for inclusion in the DJS Youth Centers Guidelines for Admission.

The Youth Centers Special Education Coordinator will disseminate the revised information regarding special education on the Guidelines for Admissions to all special education personnel in the Youth Centers by June 6, 2005.

The Youth Centers education programs will continue to provide monthly special education reports to DJS Education Superintendent. These reports document that we provide a range of special education service hours.

A joint DJS Educational Services Unit/MSDE workgroup will draft a special education manual identifying policies and procedures to be used system-wide (e.g., in all DJS and MSDE operated education programs in DJS residential

facilities.) The manual will specify procedures for full compliance with all relevant requirements, based on best practice for implementation of special education services in juvenile facilities. Initial meetings have occurred, workgroup members have been identified, and workgroup meetings are scheduled beginning June 1, 2005 with the final product due by October 1, 2005.

- The opportunity for family involvement has increased in the Youth Centers as elsewhere within DJS. Youth may have family visits up to 3 times per week: one visit on weekends; one on Wednesday; and one additional earned visit. Children of youth will be permitted as long as they are accompanied by the youth's parent/guardian, a sibling over 18 or a grandparent. Visits can last up to two hours and up to four family members can visit at a time. Frequently, the positive support network for the youth includes others in the extended family and community members as well. Special consideration should be given to these individuals where they may figure positively in the youth's aftercare and adjustment back into the community. Youth telephone contact with parents remains limited, as the youth only receive one state paid ten minute call per week, and if the youth has not lost the privilege, one ten minute collect call per week. When issues and problems come up during the call, there is little time given for the youth to work through the feelings. Also, many of the youth have families that cannot afford to accept collect calls, and these same families often cannot afford to travel to the Centers for visitation. One suggestion is to allow the families to purchase less expensive calling cards for the youth's use as a substitute for calling collect. Additionally, it has been recommended that use of video conferencing be explored by the Department as a means of providing more significant and frequent contact with family members.

**Response:**

Special consideration is given to requests for visits by non-family members of youth, and always has been. Those requests are evaluated by the Center Director and are based on information received from the youth, his family, and his treatment team at the Center. They are however, and of necessity will remain, exceptions to routine process, and considered on a case by case basis. Telephone contact must remain limited, not because we do not recognize the positive benefits in can provide, but because of the time constraints imposed by the busy activity schedules at our Centers. Creating additional telephone contact time for one or several youth would eliminate time available for other youth, creating an unjust and unacceptable situation.

- Aftercare is still a weakness with regard to youth being released from the Youth Centers. Many youth return home without adequate planning, or having to wait to enroll in school or aftercare programs. Case Managers in the Centers are charged with developing aftercare plans, but are limited by distance and not having face-to-face contact and in depth information of local resources for youth being released. In some cases, educators, particularly at Backbone Mountain Youth

Center, have developed extensive resources to help with aftercare and this is commendable and very helpful to youth. DJS community services personnel should be more actively involved in the development of youths' aftercare plans.

**Response:**

Participation by Community Justice Workers in the development of aftercare plans for youth is continually improving. Though as always, there are a few resistant individuals, as most workers become more familiar with our needs and expectations, they very willingly participate in developing an aftercare plan which will benefit the youth.

- While probation officers have visited youth more frequently in the Centers, often, the visit is very brief because of the number of youth to be visited in the various Centers and the short time available so as to allow time for the worker to return home that same day.

**Response:**

No response necessary.

The **Young Women's Facility of Maryland at Waxter** is a State-owned and operated detention/ residential treatment facility located in Laurel, Maryland. The facility houses females under the age of 18 and is comprised of one detention unit and three programming units. The facility is operated under DJS Detention Standards and other DJS policies and procedures.

The population in the facility remained just under 60 youth during the course of the reporting period. A new Superintendent, Ms. Janice Gardener, began in January 2005. Ms. Gardener is reviewing existing facility policy and procedure and establishing new protocols to refine the facility's operation. One of Ms. Gardener's first initiatives was to issue a policy establishing multiple staff meetings within and between all program initiatives to enhance communication and coordinate services. This monitor has had several productive meetings with Ms. Gardener and has found her to be concerned with the best interests of the youth at Waxter.

- **Unabated for 30 Days or More:** January through March 2005 revealed that assaults/use of force incidents increased from an average of 0.5 per day during the same reporting period in 2004 to 0.7 during this period in 2005. Measures to reduce the level of assaultive behavior and the use of force are necessary. Continued focus upon program enhancement may be of benefit.

**Response:**

With the decrease in the number of youth in the facility, we anticipate a reduction in the number of youth on youth assaults. Two programs have been removed from the facility reducing the number of youth to an average of 40. Staff received training in effective communication on reporting incidents. Training of CPM and the Behavior Management System was also instituted.

- **Unabated for 30 Days or More:** There are continued concerns over the accuracy of the ICAU database, filed incident reports, and adherence to required policy and procedure at this facility. Quality control initiatives possibly involving supervisory review of incident reports for accuracy at both the facility level and within OPRA would assist with this repeat finding.

**Response:**

We are conducting increased training for all staff in report writing and reporting of incidents.

- **Unabated for 30 Days or More:** A number of staff, upon learning of a child abuse allegation, failed to report the matter to CPS. The probation officer, OPRA (upon receipt of the case and later during its investigation), the then superintendent, and the nursing all failed to contact CPS. This matter has been addressed previously by this Office and cited in reports, particularly with regard to the nursing staff. This problem is also present within other DJS facilities and must be addressed in a more comprehensive manner in order to correct this basic deficiency that continues to be cited.

**Response:**

Child abuse and neglect procedures are very clear and the superintendents have been directed to have nurses and administrative staff notify the appropriate agency and provide them with the incident report indicating that they have reported the incident. This process will be carefully monitored.

- **Unabated for 30 Days or More:** There is still no written protocol between DJS, CPS, the State Police and the State Attorney's Office for responding to and handling abuse, assault, and other violent incidents. This issue has been previously cited a number of times by this Office. DJS's most recent Corrective Action Plan, submitted in response to the previous Timely Report states: "The MOU is still in process. A draft was sent to David Ladd, AA County DSS-Protective Services. There has been no feedback or recommendations to us relative to the draft, at this time. We will follow up on this before the next reporting period." Follow up with Anne Arundel CPS is required. This Office will be happy to assist if requested.

**Response:**

We have been meeting with all parties involved in the MOU process. While we appreciate the assistance of the monitor, we are able to facilitate the MOU agreement.

- A youth placed on Suicide Watch Level III was not provided one-on-one supervision as required. According to staff, sufficient staff coverage was not available to comply with this requirement. Consequently, direct care staff apparently downgraded the youth's suicide watch level on their own. This matter requires the attention of DJS headquarters to address the personnel shortage and that of the superintendent to ensure that policy and procedure are adhered to with regard to suicide precautions.

**Response:**

The personnel shortage is being addressed. New staff are being interviewed and will be hired as soon as they complete the hiring process. Permission has been given to hire four staff immediately. Behavior Management Training and Suicide Prevention Training were completed.

- It is recommended that a more user-friendly system be developed for line staff that documents security risks, treatment needs, supervision requirements, and suicide risks so that a review of multiple sources is not required in order to ensure the safety and security of youth. It is recommended that the DJS Suicide Prevention Policy regarding a suicide log book that requires a bound book be utilized by staff for use in each program to document the youth who are currently on a Suicide Watch Level be followed. The documentation shall include, but not limited to: (1) The youth's name and date of birth, (2) The date and time placed on the SWL, (3) The staff placing the youth on SWL, (4) The current SWL, (5) The necessary precautions, interventions and actions for direct care staff to follow, and (6) Communication from the clinical professional.

**Response:**

We will review the current process to determine if there is a more appropriate response to the treatment needs of our youth.

- **Unabated for 30 Days or More:** Staffing is still insufficient at the facility. A review of the staffing patterns during this reporting period shows a ratio of 1 staff to 8-12 youth during the day and evening shifts. However, this staffing pattern did not provide sufficient staff for required one-on-one supervision of a youth on suicide watch. In addition, the staffing pattern on the midnight shifts, was approximately 1 staff to 19 youth. Many of the staff regularly work double shifts which takes a toll on staff's ability to provide quality supervision. Assistance with staffing shortages will be required from DJS headquarters.

**Response:**

The facility has been given approval to fill four of the vacant positions. Process began in May and will be ongoing until the positions are filled.

- Given the concern with a possible AWOL attempt, consideration for additional staffing and/or security may have been in order. A review of security practices and protocol should be implemented, especially as the new superintendent is in the process of evaluating current operations.

**Response:**

We will take the monitor's suggestion under advisement. We have also requested that a secure walkway be constructed from the main building to the school trailers. The personnel shortage is being addressed. New staff are being interviewed and will be hired as soon as they complete the hiring process. Permission has been given to hire four staff immediately.

- With regard to the use of seclusion, the following issues are relevant. The pre-planned use of seclusion appears to violate DJS policies concerning using seclusion as punishment. Further, there is no documentation to support that the youth placed in seclusion were allowed to shower and have one hour of large muscle activity every day. It is recommended that Waxter implement procedures addressed in the recent department-wide training and that it review the corrective plan submitted by BCJJC. This Office maintains that due process hearings cannot be administratively suspended as this is a constitutional right of youth.

**Response:**

Again, we thank you for your input.

We will review the corrective action plan submitted by BCJJC and determine if it can be of use to this facility.

- **Unabated for 30 Days or More:** Based on accepted standards and guidelines for best practices, the population should be well under 50. The population of this facility during this course of this reporting period averaged just under 60 youth. Based on nationally recognized standards, bedrooms should house no more than one youth and dorms should house no more than five youth. Also, based on the square footage, sleeping conditions, and toilet facilities, the ideal population for Waxter should be less than 50. Nationally recognized standards require one toilet for every eight girls, one sink for every twelve youth and one shower for every eight youth with thermostatically controlled temperatures between 100 and 120 degrees. The elimination of two of the commitment programs should assist in providing additional sleeping and bathroom facilities for youth.

**Response:**

We are aware of the impact of removing the two programs. We have corrected the population.

- **Unabated for 30 Days or More:** Youth are being detained on pending placement for too long. Additional initiative to address the barriers for the placement of youth are necessary. Measures to actively involve field service case managers in this process may assist.

**Response:**

We continue to address the Pending Placement youth and we have made significant progress in decreasing the number of days for many of the youth.

- **Unabated for 30 Days or More:** Ants and spiders are present in the sleeping rooms. Prior corrective action has proven unsuccessful. Additional attention must be focused on this matter to remedy.

**Response:**

The current vendor provides monthly pest control. We are researching options to select another vendor.

**The Baltimore City Juvenile Justice Center (BCJJC)** has the capacity to house 144 male detention youth but concerns with access to the second tier handrails decreases the number of beds legitimately available. The property is owned and operated by the Department of Juvenile Services (DJS) and is governed by the Maryland Department of Juvenile Services Standards for Juvenile Detention Facilities. Due to a multiple escapes and concerns with abuse, neglect and illegal seclusions, this Office prepared a Special Timely Report on March 2, 2005. A subsequent Timely Report addressing the remainder of the quarter was also issued.

- **Unabated for 30 Days or More:** Youth on youth assaults and use of force incidents have continued to increase and a written interagency response agreement must be developed for child abuse investigations and major disruptions. Of major concern was the number of youth on staff assaults that rose from 3 and 2 in January and February, to 18 in March. Youth on youth assaults with injury also rose from 8 in January, to 15 in February, and to 25 in March. Use of Force incidents with injury rose from 5 in January, 2 in February, and to 9 in March.

**Response:**

Daily townhouse meetings will be held with each unit to discuss any problems or concerns which exist on the units. This intervention will help in resolving youth conflicts at the lowest level and should prevent the increase in youth on youth assaults.

- Seclusion, parental notification and one-on-one procedures are being violated. The seclusion issues from the Special Timely Report and other incidents reveal that seclusion has been used as punishment and youth have been kept in seclusion for lengthy periods of time. Educational and recreational services are also being denied youth in seclusion. Due to the issue of seclusion, the Department of Social Services' Child Protective Services Unit has been involved in an investigation to determine if the facility has been neglectful in its treatment of youth. This Office is aware that DJS is reviewing and modifying its seclusion policies; however, there must be a strong emphasis on maintaining the safety and rights of the youth. Staff assigned to one-on-one suicide prevention should be held strictly accountable for failing to follow procedures.

**Response:**

Seclusion will be used in accordance with DJS policy and procedure. In addition, the suicide prevention policy has been modified and distributed to all staff.

- DJS employees were observed responding to an escape attempt and they were very disorganized. DJS should implement procedures that provide for the appropriate deployment/placement of staff during incidents of escape or other emergencies that maximize security without needlessly jeopardizing the safety and health of staff.

**Response:**

We will continue to modify our procedures to ensure the appropriate response to crisis situations.

- **Unabated for 30 Days or More:** There were still numerous inaccuracies noted in incident reports. These inaccuracies skew the results of gathering information on the database and are detrimental for effective responses to the needs of the facilities and youth.

**Response:**

The inaccuracies cited by the monitor are the result of clarity of the reports by OPRA. OPRA has instructed the staff who input the information that if they do not understand the incident to record it as "other." This is not an attempt to skew the information or the results of the incidents.

BCJJC has also implemented a revised department incident report which is assisting with accuracy and detail in reports. Also, shift commanders are required to review incident reports before submission into system.

- **Unabated for 30 Days or More:** DJS must ensure that all cases of suspected child abuse and neglect are reported immediately to both Child Protective Services and State Police. There was a concern that nurses who observe suspected abuse were not contacting CPS directly, as is required by law.

**Response:**

New procedures are in place to ensure that all suspected cases of child abuse and neglect are reported as required by law. Nurses will be directed to report any alleged incidents of child abuse directly to CPS. All staff at BCJJC will receive a memo regarding their responsibility (mandated reporter) of making contact with CPS.

- Staff to youth ratios are normally being maintained but there have been several instances of forced overtime. Logbook reviews reveal that some shifts have only one staff person working on a unit at a time.

**Response:**

Hiring is occurring on an ongoing basis at BCJJC. New staff are being trained and assigned to work on the units.

- Programming and education are still insufficient. Youth are not always receiving the required number of hours for education and a review of logbooks revealed that effective after school and weekend programming is virtually non-existent at times.

**Response:**

Log books will be reviewed by supervisors and managers to ensure that the appropriate language is documented

- Mental health personnel are not being properly utilized and counselors have to wait unnecessarily for lengthy periods of time to meet with clients.

**Response:**

Mental health staff have access to see youth throughout the building and an escort is not necessary for these staff. Master Control operators will continue to work closely with mental health staff to ascertain the whereabouts of youth during the 24 hr schedule so that mental health follow up can occur.

- Master Control needs to be more orderly, organized and under control.

**Response:**

Traffic flow into the control rooms will be improved. Control room staff will receive post orders outlining their job responsibilities. One area to be discussed is keeping the area neat and clean

- The movement of youth needs to be supervised to prevent youth from different units from assaulting one another. Two incidents of mass disturbances and assaults between youth were a result of allowing two different groups to mix during meals and recreation.

**Response:**

Changes have been made to facilitate the safe movement of youth. Staff will continue to assess the group dynamics across units and will ensure the 24 hr. schedule is followed and major incidents are prevented. Necessary modifications will be made by the shift commander regarding unit interactions in program areas

- Door locks are not always engaging when doors close and they need to be maintained so they secure properly.

**Response:**

Work orders will be filled out and submitted to maintenance whenever a door is not functional. Maintenance will repair all door locks immediately when it is brought to their attention.

- **Unabated for 30 Days or More:** The dining hall serving line should have a barrier erected to prevent youth from jumping over the counter and entering the kitchen.

**Response:**

Discussions are still occurring between BCJJC administration and Capital Planning regarding the construction of a barrier for the dining hall serving line

- **Unabated for 30 Days or More:** Surveillance equipment that is broken must be repaired.

**Response:**

Work orders are always submitted promptly when repairs are needed.

- **Unabated for 30 Days or More:** Measures must still be taken to prevent youth from accessing the second tier handrails on the living units. DJS had advised that the second tier would be closed and the number of youth that can be detained in the facility would be reduced, but the second tier is still being used to house youth and the population of youth has increased.

**Response:**

It is unclear who made the decision to discontinue the use of the top tier or who advised the monitor of the change. We are however, providing a directive relative to supervision of youth on the top tier.

- The Juvenile Detention Alternatives Initiative (JDAI) is providing consultation services for future self-inspections.

**Response:**

No Response required.

- This monitor provided some technical assistance with training for child abuse recognition and reporting.

**Response:**

Thanks for your assistance in providing technical assistance and training in child abuse recognition and reporting.

The **Maryland Youth Residence Center (MYRC)** is a shelter care facility for up to thirty boys, ages 12 to 18. Under the Shelter Care Program, boys who need supervision but are not deemed dangerous are housed there while they await a court hearing or placement in another residence.

- Twenty five percent of the youth being held at the facility have been there for more than 30 days. Four youth were placed for more than 60 days, two were placed for more than 100 days and 1 was placed for over 200 days.

**Response:**

We will continue to monitor the youth pending placement and remove them from the shelter as soon as beds become available.

- Assaultive behavior at the facility has increased. There were approximately 30 - 33 youth in the facility and there were 5 youth on youth assaults in January, 6 in February and 14 in March.

**Response:**

We will continue to provide the appropriate level of supervision and programming in an effort to reduce the number of assaults.

- AWOLs at the facility have increased. There were 6 in January, 8 in February and 13 in March.

**Response:**

This is a staff secure program for non violent and impulsive offenders. They will display impulsive behaviors.

- DJS must designate the facility as either a shelter or a secure facility. If it is a shelter, staff should not be physically restraining youth to keep them from leaving the facility. During one youth's attempt to leave the facility, a staff reportedly physically restrained the youth for 45 minutes.

**Response:**

We have designated the facility as a staff secure shelter.

- Staffing at the facility is insufficient. There are 12 youth on each unit and normally only one staff supervises each unit. There should be 2 staff on every unit to respond to situations that require immediate attention.

**Response:**

We will review the monitor's recommendation to review the staffing needs to determine if more staff are required.

- Reports in the DJS/ICAU database are often inaccurately labeled. As previously stated, these inaccuracies skew the results of gathering information on the

database and are detrimental for effective responses to the needs of the facilities and youth.

**Response:**

The monitor feels that the database is labeled inaccurately. We do not. We modify the incident reporting after an assessment of the written report.

- **Unabated for 30 Days or More:** Maintenance issues continue to exist surrounding the south side bathroom and dining areas of the facility. Recent repairs to the walls and ceilings were merely cosmetic and have not eliminated the water leak problem.

**Response:**

This is on the priority list for repairs.

- **Unabated for 30 Days or More:** The facility is still in need of an additional transportation van. This Office has recommended this previously and it is necessary as a backup for transporting youth to different events, court, etc. There is only one van available for such transportation and when it is down for maintenance or being used to transport food, there is no transportation available for the youth.

**Response:**

This is the opinion of the monitor. We have access to numerous vans when needed.

**Mount Clare House** is located on the fringe of downtown Baltimore City. The facility is a two-story house owned by the Department of Juvenile Services. The vendor for this facility is First Home Care Corporation. This is a twelve-bed group home that serves male youth (ages 15 ½ - 18) who have emotional and behavior problems. The length of stay is nine months to one year. A cook on-site prepares meals. Although licensed by DJS, the group home also contracts four beds with the Department of Human Resources (DHR); four beds with the Department of Health and Mental Hygiene (DHMH) and is governed by COMAR.

- New carpeting was installed in the basement.

**Response:**

No response necessary.

- Repairs to kitchen and administrative office have stopped the leaks in the ceiling.

**Response:**

No response needed.

- This monitor observed the State Oversight Committee Meeting on February 9<sup>th</sup>. DJS, DSS, and DHMH discuss each youth progress with facility administration. Treatment and discharge plans are also coordinated.

**Response:**

No response needed.

**William Donald Schaefer House** William Donald Schaefer House is a nineteen-bed locked door facility for male youth who have a history of alcohol or drug abuse. The property is owned and operated by the Department of Juvenile Services. This is the only DJS-operated facility that is regulated and licensed by COMAR. It is located in a residential setting in north Baltimore.

Schaefer House is a 90-day substance program and is ongoing, so that as a youth completes his recovery tasks and is released, another youth can be admitted. The program consists of individual and group counseling, education, and additional off and on grounds activities that contribute to the overall program.

The program overall seems to provide youth with the opportunity to address their issues of addiction if they so choose. There are ample and very positive community activities provided by the program for youth giving them opportunities to build self-esteem and make a contribution to others.

Examples of the programming provided are: Youth Confidence Training (Y.C.T.) – a 45-day course that is similar to a life skills course. The course focuses on behavior modification, anger management, and self esteem confidence. Schooling – youth attend general studies or Pre-GED classes. The Pre-GED class has a 90% success rate with some graduates are attending community colleges. The facility's Juvenile Counselors assist youth with college financial aid packets and admissions packets. Dads 101 – sponsored by the Casey Foundation, provides this 6 week program to teach fathers, expecting fathers, or brothers of young siblings how to be a nurturing parent. In late 2004, one graduate of the Schaefer's Dad 101 course traveled to New Orleans with members of the Casey Foundation to speak at the National Teens Conference for Young Parents. Community Service – the youth distributed Thanksgiving Baskets for the United Heritage Church to needy families. The youth also participate in various community activities. A tracking system has been developed, and initial indications are positive in terms of youth not re-offending upon completion of the program.

- Staffing overall is good, but in order to be fully staffed, two vacant positions need to be filled.

**Response:**

We are aware of the vacancies and will continue our efforts to fill the positions.

- **Unabated for 30 Days or More:** With regard to youth being visited as required by their probation officers, it is reported that about half make the visits, while the other half visit infrequently, or not at all, during the stay in the program by a youth in their charge.

**Response:**

The facility will submit monthly reports to the Assistant Secretary for Community Justice on case managers' lack of visits to the facility.

The facility suffers from the poor condition of its physical plant and the furnishings. The many and various repairs needed have been consistently documented without remedy. Of major concern is the hole in the roof in the rear of the building and the bathrooms that require renovation. Cost will no doubt be significant, but many cosmetic and simple repairs could be made quickly and relatively inexpensively. New furniture should be provided especially in the youths' bedrooms. Vermin in the form of mice and lice are reported by staff and youth to be problematic. The following list illustrates the OIJM's physical plant concerns:

- **Kitchen:** The kitchen is no longer used to prepare daily meals for the youth. Meals are delivered everyday from the Maryland Youth Resident Center (MYRC). However, members of the United Heritage Church who cook breakfast for the youth use the kitchen every month. Church members prepare the breakfast to express their gratitude for the many hours of volunteer work the youth provide. Some kitchen cabinet doors have fallen off and need to be replaced. Ceiling vents are covered in a greasy substance and need to be cleaned. The floor drain under the largest sink is covered in a greasy substance and needs to be cleaned. The small sink leaks from the bottom requiring a bucket to sit underneath it to catch the excess water. The kitchen floor is dirty and requires pressure washing. The staff and youth stated the facility has mice that need to be exterminated.

**Response:**

All of the repairs have been submitted to maintenance.

- **Kitchen Storage Room:** Part of the ceiling caved in due to a leak in the ceiling. Four months later, neither the ceiling nor the roof has been repaired. The wall beside the door has a large hole in it.

**Response:**

The outside of the wall has been repaired and we are waiting for maintenance to complete the additional repairs.

- **1<sup>st</sup> floor Utility Closet:** The swing bar on top of the door is hanging down and needs to be re-attached.

**Response:**

It has been repaired.

- **Sunroom:** The caulking around some windows has fallen off resulting in cold air seeping in during inclement weather. The ceiling vents covers have been removed and should be replaced. The furniture is very old and should be replaced.

**Response:**

These repairs are on the list for modification.

- **Bedrooms:** All bedrooms have missing socket covers. Many of the exposed sockets and wiring are along the same wall as the bunk beds. Some uncovered sockets are next to the pillows of the youth that sleep on the bottom bunk. All bedrooms have old, damaged wooden dressers. Most of the drawers are broken and have missing drawer covers. Bedroom #10 - the smoke detector is hanging down from the ceiling and needs to be reinstalled. Bedroom #10 - some of the Venetian blinds have been damaged and should be replaced. Bedroom #11 - the lock on the door spins around when trying to open it.

**Response:**

The lock on bedroom door has been fixed. Many of the socket covers have been fixed and other repairs are on the priority list.

- **2<sup>nd</sup> floor bathroom:** There are two showers; however, maintenance workers removed the shower handles approximately one year ago but never replaced them. This leaves only one working shower on the 2<sup>nd</sup> floor. The tile in the showers is covered in mildew and some tiles are missing. One of the two urinals overflows onto the floor when flushed several times in a row. This occurs often because approximately 19 youth use the bathroom everyday. One of the two sinks leaks and has a bucket underneath it to catch the excess water. The socket above the sink does not have a cover on it.

**Response:**

These are on the maintenance list for repairs.

- **2<sup>nd</sup> floor hallway:** The exit light does not illuminate and the handle on fire extinguisher case is missing.

**Response:**

This is on the maintenance list for repairs.

- **2<sup>nd</sup> floor utility closet:** The faucet leaks and the cold water handle spins around.

**Response:**

This is on the maintenance list for repairs.

- **Staff area:** The telephone jack dangles from the wall and no longer works. The staff phone must be plugged into a 1<sup>st</sup> floor jack and run up the stairs through an extra long phone cord.

**Response:**

This repair has been completed.

- **3rd floor bathroom:** The fixture in one of the showers will not turn off properly. The staff and youth have to twist it up and down then pull it in and out before the water will stop. Both sockets over the sinks show evidence of burning. The staff no longer allows the youth to use the sockets; however, the hazard of a possible electrical problem continues to exist.

**Response:**

These repairs are on the list for repairs.

- **Laundry Room:** The laundry room consists of two washers and two dryers. Unfortunately, one of each is broken. This leaves one washer and one dryer for approximately 19 youth to use, at least, on a weekly basis. The commercial washer was designed to require quarters to operate it; however, the cover was removed and the youth must stick their hands inside of a small area to turn the switch on. The washer lid is rusting from the inside out.

**Response:**

A request has been made to purchase one heavy duty washer and dryer.

- **Boiler Room:** The door to the circuit breaker case will not close and should be repaired or replaced. The screens covering the windows are so old that they are rotting away. This allows leaves, dirt, rodents, etc. to enter through the windows.

**Response:**

This is on the list for repairs.

- **Recreation Room:** This area is filled with mold and mildew on the walls, windows, exposed pipes, and ceiling. The gym mats are covered in dust and dirt. There is no outside ventilation for this area because the windows remain closed. Cobb webs cover the windows. Three very old file cabinets sit in the middle of the room. The paperwork in the cabinets is from the 1990's and is now discolored. The older model weight equipment was donated and is pretty much scattered around the room. It is unclear if the equipment is serviced or inspected for safety. The legs on the foosball table are uneven and propped up by weights. The ping-pong table is used as a storage shelf. Staff and the monitor could not locate the net or paddles that accompany the table. The door on the fire extinguisher case is broken and needs to be repaired or replaced.

**Response:**

Requests have been made to maintenance to correct all of the problem areas.

- **Exterior:** The gutters leak and need to be replaced. The leaking water has caused the wood around some windows to rot.

**Response:**

Requests have been made to maintenance to correct all of the problem areas.

**Catonsville Structured Shelter Care (GUIDE)** is a privately operated non-secure facility located on Department of Juvenile Services' property. The current license allows for a capacity of ten male youth. The current vendor is held accountable for its services by Code of Maryland Regulations (COMAR) and certain Maryland Department of Juvenile Services licensing requirements.

- The facility continues to provide the residents were a positive programming schedule. The youth are integrated into the community for events. Youth are provided with an adequate amount of instructional time.

**Response:**

No response needed.

- The youth perform a number of community service hours at Paul's Place, a local soup kitchen.

**Response:**

No response needed.

- **Unabated for 30 Days or More:** This Office has identified the following physical plant issues:
  - The kitchen, dining room, and bathroom floor tiles need to be repaired. The structural integrity of the kitchen floor remains a concern.
  - The pressboard on the kitchen cabinets has suffered water damage and need to be replaced.
  - The large fallen tree on the premises that has been previously cited remains a safety concern.

**Response:**

Requests have been made to DJS maintenance to repair or correct the areas of concern.

The **Charles H. Hickey School** is the Department of Juvenile Services' largest facility (between 165 and 185 youth), which is comprised of detention units, and programming units designed for 30 days to 18 months programs.

- Population at the facility remained comparatively consistent, fluctuating between 165 and 185, while assault/use of force incidents per day increased from an average of 1.6 per day last quarter to 1.9 per day for this quarter. There are still concerns about particular staff abusing youth as reports of abuse/neglect climbed from 7 last quarter to 12 this quarter.

**Response:**

Any allegation of abuse is aggressively reported and investigated by Child Protective Services (DSS), Maryland State Police and OPRA (DJS). Any sustained finding results in severe disciplinary action, normally, dismissal. This aggressive reporting is evidenced by the abundance of caution in reporting to CPS any incident that may be interpreted as abusive. At the writing of this report, none of the incidents reported during this quarter have been sustained as abuse by any of the three investigative agencies reviewing the allegations.

- This Office continues to provide technical support to DJS, teaching classes to Hickey personnel on "Child Abuse Recognition and Reporting" and "Juvenile Rights."

**Response:**

We appreciate the monitors' assistance with the training and technical assistance.

- Youth obtained two pairs of 8" scissors from the education trailer in the detention area some time prior to February 20 and both pairs were subsequently used to effect escapes and assaults on February 20 and March 30.

**Response:**

The Maryland State Department of Education who oversees the operation of all educational services and staff at the Hickey School has implemented stringent controls of all classroom implements as a result of this incident. All youth are subject to a "pat down" search by DJS Staff prior to entering and when leaving the educational setting. All housing Units are searched for contraband on a regular basis and contraband policies and procedures have been reinforced with all staff.

- There are concerns that seclusion is not being used properly. On 3/18, this monitor interviewed a youth on seclusion and determined that he had been in the infirmary/seclusion area for the past 6 weeks due to an injury to his foot that became infected due to a lack of proper medical attention. The youth stated that the only education services he had received was a packet sent over to him by the school that he completed and he stated he never received any feedback about what he had done.

After a complaint initiated by the Baltimore City Public Defender's Office, an investigation was completed by DJS to determine if another youth had been improperly placed in seclusion on 3/11 and he had been deprived of educational services and large muscle activity while in seclusion (ICAU Report Number 27900). The ensuing investigation resulted in a finding that determined staff had violated DJS policy concerning the use of seclusion.

**Response:**

After reviewing this report Hickey Administration caused a review of the complete medical files of the youth interviewed on 3/18/05. Independent DJS staff that possessed valid medical credentials conducted the audit. It was determined that the youth was provided all appropriate medical attention while at Hickey and at local hospitals. Had the Monitor reviewed with the Medical Director, or the Facility Administrator the allegations made by the youth, he would have learned the truth. The youth was routinely provided educational materials and hid them in his room, destroyed them when provided, or simply refused to complete them. This incident demonstrates the need for inexperienced monitoring staff to consult with Facility Administration prior to reporting inaccurate data.

As a result of the monitor's allegation concerning the use of seclusion, the Seclusion and Infirmary Staff now ensure that educational materials are received and collected from each youth. The facility continues to aggressively refine and monitor the use of seclusion as a means of ensuring the safety of all youth and staff.

- There were 17 incidents of suicide ideation, gestures, behavior and attempts during the quarter.

**Response:**

The staff continues to aggressively respond to any possibility of a youth potentially harming himself. Any iteration results in an assessment and counseling by clinical staff and intensive monitoring by the direct care staff as deemed appropriate.

- A youth was improperly released to the custody of a person who was not his legal custodian.

**Response:**

The youth was released to a family member (sister) based upon a memorandum from the Court stating the youth was eligible for release if the Department could locate a "legitimate parent or guardian". The staff contacted the guardian the following day and the youth was returned to the facility. In order to prevent a similar incident in the future, in the absence of a signed Court Order, the DJS Field Case Manager must forward documentation on DJS letterhead, or via secure

intranet specifying the exact conditions of release and the specific person acceptable to accept the release of a youth in our care.

- **Unabated for 30 Days or More:** There were still many inaccuracies in the labeling and entering of information in the ICAU incident report database.

**Response:**

The misunderstanding of how information is recorded continues to be an issue for the monitor. OPRA reviews all of the written reports and provides clarity to the information and will modify the incident to reflect the correct labeling. This is not an effort to change but to correct.

- Facility staff who are under investigation should be closely monitored for retaliatory behavior to protect both youth and staff at the facility. A upset staff person who had been suspended without pay for an investigation, had been allowed to enter the facility and could have been a threat to youth who were witnesses/victims in her case.

**Response:**

The staff was allowed into the Administrative offices of the facility consistent with completing the investigation of her involvement in an alleged incident. The staff was not allowed access to the secure inner perimeter area where youth are housed, nor was she allowed to interact with any youth. Any allegation of retaliatory behavior is reported and thoroughly investigated by DJS at a minimum CPS and the State Police should there be allegations of any physical altercation. The singular allegation that the monitor addresses was decisively addressed by the Administration and we concur with the monitors' assessment that they should not be involved in DJS Personnel issues.

- **Unabated for 30 Days or More:** Population/staffing ratios have been satisfactory overall but staff are still working a significant amount of overtime. Overtime staff are often overworked and tired as Hickey administrators attempt to maintain adequate coverage. Sleeping staff persons have contributed to escapes.

**Response:**

Please provide documentation that staff was sleeping and it contributed to the attempted escapes. DJS investigations did not reveal sleeping staff in any escape or attempted escape. Recruiting efforts to hire and train additional staff are ongoing as expeditiously as practical consistent with State of Maryland employment policies.

- **Unabated for 30 Days or More:** Programming has improved overall but there are still concerns about the lack of sports programs and after-school/weekend activities for the detention population. There are no hands on vocational programs such as auto shop, wood shop, etc.

**Response:**

The Department is actively recruiting for additional recreational staff to enhance youth recreational needs.

- Illegal contraband and suspected illegal substances that are recovered at the facility should be processed according to established procedures and evidence should not be improperly handled. Staff from master control who was processing paperwork was observed opening an envelope containing suspected cocaine.

**Response:**

Evidentiary protocols are in place and enforced. As a result of the monitors report the staff involved in this case was counseled concerning this violation of DJS directives.

- The facility is still in need of another transportation vehicle that is safe and legally operable.

**Response:**

The Department is replacing vehicles as fiscal resources permit. Every vehicle is serviced as required and maintained with the safety of the youth being transported always at the forefront.

- Kitchen staffing is down and adequate supplies for the kitchen are not always being maintained. Staff said the kitchen needed 1 more truck driver, a cook and 4 personnel to serve youth on their units.

**Response:**

Additional food service staff have been hired and the staffing level is currently adequate to provide service to the youth in our care.

- **Unabated for 30 Days or More:** The entrance gates for the vehicle and pedestrian sallyports were not always functioning properly.

**Response:**

The vehicular and pedestrian sally port gates and actuator hardware and motors (drive system) have both been replaced in the last 10 months at a total cost in excess of \$15,000. The process was a lengthy one due to compliance with Maryland procurement regulations. A remote control unit is currently in use to activate the vehicular sally port.

- **Unabated for 30 Days or More:** The parking lot at the entrance to the facility still needs to be expanded. The driveway to a house adjacent to the entrance is being utilized for parking and has relieved some of the congestion, but the roadway adjacent to the parking lot is still often crowded with vehicles that both block the safe entrance into the facility, and cause hazardous ruts and holes in the dirt alongside the roadway.

**Response:**

Parking adjacent to the roadway was stopped in January 2005, prior to this report, as a safety issue for pedestrians, and to ensure emergency vehicle access to the facility should that be required. We agree that the expansion of our parking capability is needed, and is currently under study the DJS Maintenance staff.

- **Unabated for 30 Days or More:** Even after repeated citations by this Office, the ceiling vents on the bedroom units are not suicide proof. There was another incident where a youth tied a sheet through his ceiling vent and was planning to commit suicide except for the actions of an alert staff. The renovation of Ford Hall should include plans for replacing/repairing the ceiling vents, recessing the bedroom lights or making sure the toilets and plumbing are constructed to prevent breakage or access.

**Response:**

This issue has been addressed in prior reports.

- **Unabated for 30 Days or More:** Previous citations by this Office for a lack of security surveillance cameras have failed to result in the installation of these critical devices.

**Response:**

The facility has been wired with fiber optic cable for telephone and video. The acquisition and installation of surveillance video capability is proceeding consistent with fiscal capabilities.

The **Thomas O'Farrell Youth Center** is a privately run facility on state property which houses 43 adjudicated delinquent young men on the main campus and an off-campus Transitional Living Continuum shelter care (TLC) houses 7 more.

- Incidents of assault, use of force and violence decreased to 7 in January but increased to 12 in February and 16 in March. The actual assault numbers indicate there is an increase and the damage that is being done inside the facility (holes in walls) are also indicative of the aggression being displayed. There is also a concern that staff persons may not be recording the activity appropriately as required by DJS policy and procedures.

**Response:**

The administration was fully aware of the increase in use of force and youth on youth assaults. During this period of time the program was and continues to undergo significant restructuring including the dismissal of staff who may have provided inadequate supervision of youth; increase training and a new supervision structure. It must also be noted that the instances of youth on youth violence during this period of time involved one or two youth who were involved in a majority of the situations. TOYC has worked diligently with DJS to address their

individual needs. Furthermore we are confident that as a result of the restructuring the number of youth on youth assaults will dramatically decline.

1. Problems continue with escapes and attempts to escape. According to the DJS/ICAU Incident database, there were 8 escapes from the staff secure facility during the 3-month monitoring period.

**Response:**

What is not effectively borne out in the statistics provided through the incident reporting data base is the number of youth who were returned to the program subsequent to their classification as AWOL. In fact O'Farrell often reports youth as AWOL more quickly than is required by DJS. Many of these youth subsequently are returned to the program prior to the required reporting timeline. Furthermore in working with DJS O'Farrell has infrequently taken youth who were at greater risk of flight. Working with these youth offers greater reward but also poses greater risk for flight. As noted in the above response the significant restructuring at the program combined with a concerted effort to acquire qualified staff will address the. Subsequent investigations of the AWOL of youth led to immediate termination of employment of the responsible parties.

- Tool control and safety procedures must be adhered to. This monitor observed an open box of meat cutting knives sitting next to a desk in a kitchen office. The office was unsecured and accessible to youth in the area.

**Response:**

An investigation into the observation the independent monitor made in reference to an open box of knives in the kitchen staff office found that the kitchen staff were present in the kitchen supervising the youth who were present. O'Farrell's Administrative Director provided direct supervision to the Kitchen Supervisor and his staff regarding the safety procedures concerning kitchen utensils. While the youth were under constant supervision the Kitchen Supervisor recognized the need to secure kitchen utensils at all times when not in use. Periodic checks by the Program Director and the Administrative Director have found that the kitchen staff is consistently following the safety protocols.

- As of 1/17/05 the facility housed 26 youth designated as special education. There are still concerns around designation and space for level five special education.

**Response:**

The Department of Juvenile Services working with the Administration at O'Farrell and the North American Family Institute has committed to providing the resources necessary to provide youth with full day special education services. It is our goal that by the next tri-mester the resources will be in place.

- The behavior of staff and recent terminations are a concern. Staff persons must remain alert at all times. Staff persons have been found sleeping by youth on the unit and they stole his cigarettes from his pocket while he was sleeping. A youth escaped from the facility on 2/15/05 due to staff negligence. Staff persons have been observed playing very loud music in their vehicles parked behind the school trailers during lunchtime.

**Response:**

As noted in the previous responses the Administration at O'Farrell has been in the process of restructuring. Staff who have not demonstrated the potential for working in a professional manner have been terminated. Ongoing training will ensure that current and new staff maintain a level of professionalism expected by NAFI and DJS.

- Outside maintenance issues and the appearance of the exterior have greatly improved; however, maintenance issues continue to exist surrounding the daily upkeep and appearance of the interior of the facility and the operation of certain equipment in the kitchen/dining area.

**Response:**

We are acutely aware of the physical plant issues at O'Farrell. NAFI has invested more than \$30,000 in renovating the physical plant. We continue to work with DJS to improve the physical plant.

The **Sykesville Shelter Care Facility** is a structured shelter care facility that provides high levels of care for 100-120 at-risk female adolescents per year, ages 12 through 18, for a maximum of 90 days. The program houses up to 10 females at any one time.

- This facility continues to provide outstanding services to the females who are appropriately placed in its program. The administrator of the facility recently gained access to the DJS ASSIST program to help identify the needs of youth being recommended and/or selected for shelter placement at the facility.

**Response:**

We will take the monitor's recommendation under advisement.

- The population fluctuated between 6 and 9 during this monitor's visits.

**Response:**

No response needed.

- The staff to youth ratio was found to be very high throughout the reporting quarter. There is normally two or three staff at the facility on each shift.

**Response:**

No response needed.

- There were five AWOL incidents during the 3-month period. Two occurred in January and three occurred in March. The police responded to each incident and the youth were recovered unharmed.

**Response:**

No response needed.

- Females at the facility always appear to be engaged in schoolwork, basketball, or some other structured activity whenever this monitor has made visits. Youth supplement their on-grounds recreation with swimming and the utilization of physical exercise equipment at the local YMCA 2 days a week. Youth also attend movies off-grounds, attend field trips, visit the elderly and participate in the selection of and assist in the preparation of their meals. Youth state that staff persons allow them to be creative in their activities and they always feel respected by and safe with staff.

**Response:**

No response needed.

The **J. DeWeese Carter Children's Center** is a 24-bed detention facility located in Chestertown, Maryland. The facility houses both males and females between the ages of 12 and 18 years old. The facility operates under DJS Detention Standards and other DJS policies and procedures.

- **Unabated for 30 Days or More:** The facility continues to operate without a fulltime Superintendent. The Department of Juvenile Services stated that it is assessing the need for a full time Superintendent at the facility.

**Response:**

A full time superintendent has been assigned to the facility.

- The facility's population ranged from approximately 10 through 16 during the reporting period.

**Response:**

No response necessary.

- **Unabated for 30 Days or More:** The staff continues to be overworked due to a staffing shortage. Because the facility houses male and female youth, a female staff member must be on duty at all times to conduct strip searches and monitor showers. The female staff member temporarily reassigned from Lower Eastern Shore Children's Center (LESCC), returned to the LESCC due to a 2-hour

commute. Only four female staff remained to provide coverage for a twenty-four hour per day/seven days per week schedule. The women worked many hours of overtime on a weekly basis and morale was very low. The male staff also became overworked after temporarily losing one male staff member.

**Response:**

The facility has been engaged in interviewing and recruiting. Since March 21, 2005 Transportation officers have been assisting with security and supervision

- The supervisory staff complained of a lack of administrative leadership. However, in March, the facility's management team collaboratively completed a plan to re-establish Carter's positive program. Staff morale has begun to show signs of improvement.

**Response:**

No response needed.

- A disturbance occurred in March where two youth physically attacked a third youth. When the two male staff intervened, the youth assaulted them. Police assistance was needed to quell the disturbance but staff stated that they were verbally reprimanded by the acting superintendent for dialing 911..

**Response:**

No reprimand was given. A disturbance procedure does exist however, the procedure is undergoing revision. Team building is an on going process as demonstrated through case management meetings and staff meetings.

- The education program continues to provide exceptional services, although the low morale affected all aspects of the facility's program. The education staff and direct care staff will continue tutoring the youth two times per week in the evenings as well as organizing special events for the youth.

**Response:**

No response required.

- An orientation process for newly admitted youth is being implemented. Before the youth is placed in general population, he/she will meet with a staff from group life, education, mental health, substance abuse, and case management. The youth will acknowledge each session by signing their name on a sign off sheet. The youth will then be given a tour of the facility by a "level three" youth as a staff member monitors. The "level three" youth will explain group life, school, the point system, bathroom rules, and mealtime rules.

**Response:**

No response required.

- The condition of the physical plant has declined within the past year. The walls need to be painted and many upgrades should be made to improve the facility's appearance. In February, a youth damaged two wooden doors leading to the intake area and sleeping area by applying pressure to the handles. The doors should be replaced with a more secure fixture designed for detention facilities.

**Response:**

All bedrooms except 2 and 1 bathroom have been painted. New doors have been ordered.

The **Alfred D. Noyes Children's Center (Noyes)** is a State owned and operated detention facility that houses both males and females under the age of 18. The facility operates under DJS Detention Standards and other DJS policies and procedures.

On February 1, 2005 the Office of the Independent Juvenile Justice Monitor became aware of allegations concerning child abuse at the Alfred D. Noyes Children's Center. This Office notified the Department of Juvenile Services Office of Professional Responsibility and Accountability (OPRA) and the local Department of Social Services (DSS). The Montgomery County Police Department also opened an investigation into the allegation. The agencies involved worked cooperatively and shared the information gathered in accordance with Article 88§6(b), which allows for the sharing of reports or records concerning child abuse or neglect. On March 28, 2005 the Office of the Independent Juvenile Justice Monitor issued a Final Special Timely Report documenting a number of child abuse allegations at the Noyes.

This Quarterly Report will address the issues cited in the Special Timely Report with regard to the child abuse allegations as well as the subsequent Timely Report covering the remainder of this reporting period.

- DJS must ensure that practice conforms to existing policy, procedure, regulation and law in regard to child abuse allegations.

**Response:**

We have already provided the corrective actions addressed in the special report.

- DJS should implement procedures to clarify that a facility director or other facility staff should not initiate an investigation into allegations of child abuse within their facility as OPRA clearly has this internal investigative responsibility.

**Response:**

The previous Corrective Action from the Special Report is attached.

- A youth stated that other residents were accusing him and another youth on the unit of being “snitches”. At this point in the investigation only this youth on this specific unit had been questioned about the alleged abuse. Information concerning this youth’s disclosure may have been communicated among staff.

**Response:**

The previous Corrective Action from the Special Report is attached.

- DJS should ensure that practice does not allow for youth to exercise control over other youth.

**Response:**

The previous Corrective Action from the Special Report is attached.

- DJS should take action to prevent staff from using food as a reward or punishment. Youth are entitled to full portions at mealtime. Staff ordering or bringing in food should secure supervisory approval.

**Response:**

The previous Corrective Action from the Special Report is attached.

- DJS should ensure that mail is not read by unauthorized staff and aloud in the presence of other youth so as to humiliate.

**Response:**

The previous Corrective Action from the Special Report is attached.

- DJS must ensure that the use of seclusion conforms to existing policy, procedure, and regulation

**Response:**

The previous Corrective Action from the Special Report is attached.

- DJS must ensure that supervisory staff review facility operations with regard to existing policy, procedure, regulation, and law and that when a breach of protocol is suspected or detected, that supervisory staff takes appropriate action.

**Response:**

The previous Corrective Action from the Special Report is attached.

- DJS must monitor to ensure that staff do not permit or bring into the facility items considered as contraband.

**Response:**

The previous Corrective Action from the Special Report is attached.

- Staff should be held accountable for failing to properly search youth and confiscate contraband as required

**Response:**

The previous Corrective Action from the Special Report is attached.

- DJS should implement procedures to ensure that official reports are filed, maintained, and stored in a secure fashion.

**Response:**

The previous Corrective Action from the Special Report is attached.

- DJS Child Advocates must function specific to their assigned duties. The assigned Child Advocate in this facility, in order to assist with the urgent staffing needs and direct care of youth, over time assumed the duties of direct care staff. This corrupted his role and his ability to objectively serve as a Child Advocate.

**Response:**

The previous Corrective Action from the Special Report is attached.

- OPRA should monitor grievance documentation to ensure the Child Advocates are functioning as the youth's non-legal representative within the facility.

**Response:**

The previous Corrective Action from the Special Report is attached.

- The agencies involved in this investigation should be commended on their thoroughness and the cooperative manner in which they worked which resulted in a comprehensive and systemic set of findings. However, due to the lack of written protocol between all involved agencies, the initiation of the full investigation was not well coordinated. A written interagency agreement with all parties, similar to the one governing child abuse investigations in Baltimore County with regard to the Hickey School, would clarify roles in future cases of alleged child abuse and neglect at Noyes.

**Response:**

We continue to meet to develop the written interagency agreement and we will meet until the document is completed.

- **Unabated for 30 Days or More:** Until the vacant direct care staff positions are filled, it is critical that more than one staff be placed on a unit to provide the required level of supervision and to ensure the protection of residents. Without this additional coverage, the ratio will continue to be one staff for approximately 15-20 youth, which far exceeds national standards, best practices, and DJS's articulated goal of a 1 to 8 ratio. On March 23, 2005 the facility population was 57 youth. The three male units had 19, 15, and 11 youth each. The female unit had 12 youth. The use of transportation personnel may be an available resource on a temporary basis.

**Response:**

We have officially assign four (4) Transportation Officers to Alfred D. Noyes Children Center (ADNCC) to provide transports, escorts, searches, perimeter inspections and supervision of youth which augment coverage.

- A number of pending placement youth had excessive lengths of stay; 88 days, 72 days, and 70 days. This Monitor has found the DJS placement process to be very complicated and inefficient as evidenced by the many youth in facilities throughout Maryland who languish in pending placement status. DJS should make a systemic review of its policies and procedures drawing upon the expertise of its field personnel who may be able to offer viable suggestions to improve the efficiency of this process. In addition, given the fiscal crisis faced by DJS, the pending placement problem is likely only to become more pronounced. Emergency measures and planning should be developed and implemented to address the treatment needs of youth and alternative means to provide for their needs.

**Response:**

We will continue to engage in assertive case management, contacting programs, interacting with admissions officers to expedite placement of youth

- A review of the ICAU Incident Report Database for January through March 2005 shows that assaults/use of force incidents increased monthly: January - a rate of .3 per day; February – a rate of .7 per day; and March – a rate of .9 per day. The quarterly average of assaults/use of force incidents averaged .6 per day. There were also 10 suicide ideations/gestures/ or attempts during the quarterly reporting period for an average of .1 per day. Immediate Measures are required to reduce this level of serious incidents. Increased staff should assist.

**Response:**

We will continue to report incidents as required. Incidents are declining due to more structured programming. A Behavior Modification Program is now in place. The total number of incidents in April was significantly lower than March. We have implemented a more structured daily schedule from wake-up to lights outs. Increased staffing is being conducted through aggressive recruiting.

- Some of the log books contained more detail than noted in the Special Timely Report but entries are still not consistently entered in a uniform manner. The quality of entries appears reflective of which staff are working and not the requirements mandated by DJS. Training on log maintenance should be implemented. Supervisory review on each shift should occur with regard to log entry.

**Response:**

We will conduct facility specific logbook documentation training by June 30, 2005.

- Some supervisory presence is noted on the unit, and there are some supervisory reviews of log entries noted, but, again, the inclusion of this information is inconsistent. Shift supervisors should review and sign all logbooks during their daily inspections of the facility. Facility Directors should review and sign all logbooks on a weekly basis.

**Response:**

Administration will continue to encourage and monitor management's review of logbooks during visits and document the results of visit and instructions issued to staff.

- A lone staff person on duty during the day shift, upon her arrival to work, did not have the special form provided to alert her that she was charged with supervising a youth on suicide watch. The appropriate paper work did not arrive on the unit until 10:00 AM, three hours after the start of the shift. Supervisors should be required to monitor that suicide watch procedures are closely followed and ensure that the appropriate documentation is maintained and available to staff.

**Response:**

We will review suicide watch procedures with management, issuing a verbal directive for strict compliance. The Suicide Prevention Policy will also be reissued and monitored closely.

- It does not appear that the necessary suicide watch log book was on the unit or maintained accurately so that the worker could verify the suicide status of a youth. Again, supervisory staff need to ensure that the appropriate documentation is maintained.

**Response:**

We will review, revise and reissue shift change procedures. Develop shift change report to include notification of behavioral alerts, special handling and suicide watch.

- **Unabated for 30 Days or More:** The female residents complained that ants are present in their rooms and that the ants get into their net laundry bags. Previous

actions to address this issue have not been successful. Additional attention to this issue is required.

**Response:**

The exterminator visits will be increased until the issue is permanently resolved

- **Unabated for 30 Days or More:** Youth still are not receiving any regular outside recreation. It appears that the lack of staffing continues to be used as the rationale for not allowing youth outside recreation. Youth complained of the need for more activity and a variety of activity. Structured programming must be in place, especially in the absence of educational services during planned breaks in the academic schedule. Facility administration must prioritize this as a required component of programming. Despite repeated findings by this Office, this matter remains unabated.

**Response:**

Management has been instructed to utilize the outside recreational area for the heavy muscle activity period recorded on the units daily schedule.

Implement Activity Roster to record outside recreation and special activities attended y youth

- **Unabated for 30 Days or More:** The hiring of specialized staff to administer the recreation program is also required. The filling of this position would assist with ensuring that the facility meets the above referenced standard. Active recruitment must occur.

**Response:**

We will continue to actively recruit for direct care positions, inclusive of recreation personnel.

- Not all staff are equipped with radios at all times on the units. Staff are also not equipped with a duress device and must rely upon the facility's telephones which are affixed to the dayroom walls and which would be utilized in an intercom mode in an emergency call for help, announcing the crisis to both staff and youth throughout the facility. Further, the facility is without a video monitoring system. A video monitoring system would prove beneficial in reviewing the facility's operations. The above referenced security enhancements should be undertaken as soon as possible.

**Response:**

Radios will be issued to all staff on duty, administrative, management, direct care, and transportation, medical and case management

The **Cheltenham Youth Facility (CYF)** is a state owned and operated facility located in Cheltenham, Maryland. The facility has four detention units and one 24-bed shelter. The

facility operates under the DJS Detention Standards and other DJS policies and procedures.

- The total population during this reporting period ranged from approximately 70 to 90 youth.

**Response:**

No response required.

- Many new facility policies have been implemented in an effort to improve living and working conditions within the facility. Staff are now randomly searched upon entering through the front gate. Also, direct care staff are now prohibited from bringing cell phones to work with them. Further, parents are no longer permitted to enter the facility without a staff escort to the Tour Office.

**Response:**

No response required.

- The number of violent incidents has been reduced during this reporting period. However, five group disturbances did occur without any serious injury. These incidents were able to be quelled by staff and did not involve assistance from law enforcement. There were two youth on staff assaults reported. A staff member was disciplined for horse playing with a youth that resulted in a knot on the boy's head. Both the youth and staff admitted to the horseplay and inappropriate conduct.

**Response:**

No response required.

- In previous monitoring reports, this writer cited excessive use of seclusion by administration. During the reporting period, the length of time that youth spend in seclusion has been drastically reduced. Administration has been following the DJS seclusion policy by reviewing each youth's seclusion status every 2 hours. During the week of March 10 – 19, the facility did not have any incidents requiring the use of seclusion.

**Response:**

Thanks for recognizing our progress.

- On February 11<sup>th</sup>, a youth was found asleep in his room after the remainder of the unit and staff went to the dining hall for breakfast. Neither the cottage staff nor tour coordinator realized the problem with the count before leaving the unit.

**Response:**

The incident on 2/11/05 was an isolated incident where staff failed to conduct a physical count prior to leaving the unit. Upon reaching the Dining Hall and

conducting a second count the mistake was realized and a staff member immediately returned to the unit to get the youth. Shift Commanders now provide oversight control of all movement and oversee all physical counts. The Tour Office ensures at least eight Official Counts are conducted daily and assist along with the Gatehouse Staff in monitoring movement. Physical Counts are conducted by staff after each movement and randomly throughout the shift.

- The facility's mental health unit has been reduced to one mental health professional. A contractual psychiatrist prescribes the youth's mental health medication and monitors the effectiveness. However, only one mental health associate is responsible for providing mental health services to the youth on a daily basis as well as being on call for emergencies.

**Response:**

Presently a collaborated effort between Cheltenham Youth Facility and the Prince George's County Health Department is being forged to ensure adequate Mental Health Services are provided to the youth assigned to Cheltenham Youth Facility until a full time Therapist are hired. Already the Prince George's County Health Department has agreed to assign two therapists to Cheltenham with a tentative start date of June 1<sup>st</sup>.

Presently although understaffed the Facility's Mental Health Unit provides appropriate mental health services in addition to emergency interventions and re-assessments.

- Many of the staff radios are old and damaged causing interference during transmissions. Cheltenham staff rely on 2 way radios to communicate when they are not able to use the telephones.

**Response:**

On April 11<sup>th</sup> the Facility Administrators met with the IT department and were advised that 55 new two radios will be issued to the facility with a tentative date of mid May. In addition a repeater will also be installed to reduce interference and expand/ improve both existing and future communications.

- The shower area in McGuire Cottage shows signs of mildew.

**Response:**

A work detail has been developed and assigned to ensure that the Intake Area and the remainder of the building are cleaned daily.

- When a staff member found pictures that were inappropriately taken of two partially dressed youth posing in a provocative manner in the seclusion area of the Infirmary, administrators immediately contacted the DJS Office of Professional Responsibility and Accountability (OPRA) investigators. However, OPRA refused to conduct an investigation citing the lack of Departmental policy

prohibiting staff from taking personal pictures of DJS youth. Nor did OPRA direct facility administration to contact Prince Georges County Department of Social Services (DSS). Administration conducted an internal investigation and learned of several allegations against a female staff member. The allegations include taking bringing a camera on grounds, taken pictures and having them developed at a Wal-Mart Department Store, allowing seclusion youth to use her cell phone, and giving a youth her cell phone number. The allegations became more serious because the female staff member in question stated that one of her male supervisors was sexually harassing her. After completing the internal investigation, administration again requested OPRA conduct an official investigation. The investigator refused to take the photos and statements. This monitor contacted the Assistant Director of Investigations questioning whether an investigation by his unit should have been conducted. This monitor cited a youth's right to confidentiality but was told that the pictures were taken with a digital camera and Departmental standards do not prohibit staff from taking personal pictures of youth. When told that the pictures were developed at a Wal-Mart, he stated that he wasn't aware of that information. However, the allegation of inappropriate conduct of staff was never investigated by OPRA.

**Response:**

The OPRA investigators do and have investigated misconduct. In addition they provide subject matter expertise in policy infraction. After consultation with the OPRA investigators, the incident mentioned was investigated and appropriate action taken.

Staff are prohibited from entering the grounds with cameras and have been advised of the consequences if found in violation.

- DSS/CPS was not contacted in the above noted incident involving alleged exploitation of youth.

**Response:**

Appropriate action was taken in regards to the above named incident.

The **Western Maryland Children's Center**, located in Hagerstown, accommodates up to twenty-four youth. Core staff have dedicated themselves to creating and enhancing the educational and treatment environment and programming. Staff at the WMCC have continued to provide increased programming and have maintained a positive atmosphere and culture for the youth. Because of this, most of the problems that arise with the youth are addressed before they escalate. Incidents and assaults are generally infrequent, and WMCC has only had to resort to the use of seclusion on two occasions as of this writing. The level program, which offers graduated privileges and responsibilities, is implemented effectively, and the general respect that youth demonstrate for staff is a reflection of the attitude of respect and care that the staff demonstrate toward the youth. Youth on the "gold band", for example, are eligible to be on the student advisory council, which

provides the opportunity to bring issues and suggestions to the Administration. In addition to the level programming, WMCC has implemented other program enhancements as well. There is a Young Fathers program, and family visitation has been enhanced. The new Social Worker, Mr. King, is conducting anger management sessions on the units. The School Improvement Team, which is made up of representatives from different departments, is planning activities including outside speakers. The Recreational Director, when not called into direct coverage, has arranged a number of special activities and events for the youth. Staff from all departments pitch in to create special holiday activities and events for the youth.

Every Tuesday afternoon WMCC hosts Area 3 staff in order to review each Area 3 youth in the Center. Pending placement youth are given priority in working to expedite their release from WMCC and enrollment into the receiving placement program.

The biggest challenge to maintaining the programming at WMCC is the issue of staffing. Staff shortages, unfilled vacancies, forced overtime, having to use non-direct care staff in coverage, long commutes for staff that were hired from Allegany County, denial of leave requests, and stronger staff having to cover for weak staff are all issues that affect morale and could affect programming.

The other issue of concern is the facility itself. Many needed changes have been previously identified without remedy. The use of dangerous substances and fixtures within the facility creates an ongoing hazard to youth and to staff. Confidentiality is compromised by the use of see through glass in the control room, and lack of fencing to prevent outsiders from approaching sleeping room windows. These and other physical plant concerns should be addressed without delay.

- **Unabated for 30 Days or More:** Staffing continues to be inadequate at WMCC. On the two locked pods housing six youth each, there is single staff coverage. At times there is no roving staff, and at times, there is only one male in the facility which accommodates up to 24 male youth, sometimes very challenging youth. In facilities housing female youth predominately male staff coverage of females is not acceptable. The reverse should likewise not be permitted. In addition to the privacy issue, safety is often compromised.

**Response:**

Two staff on Pods A and B would result in a ratio of 1:3. Although this would be welcomed as helpful, it certainly may not be fiscally sound. Staff on those pods are monitored intermittently by the control room via two cameras on each pod. The staff wear a duress alarm which they can press when needed. The staff carry a two way radio for which they can request assistance. There is a phone on the pod which may be utilized to communicate. First and Second shifts have a supervisor and rover on the majority of shifts, as coverage allows.

These persons should be in and out of the pod. Procedures were written in which the control room operator can activate a duress code and staff persons respond to that area to assist.

- As previously reported, the hiring of staff that are unable to provide the security needed presents life, safety and security issues. Just because a new recruit passes the exam and completes a training course does not ensure in itself that the staff is competent in supervising all populations. Care must be taken to place staff where they can provide for the safety and security of youth and themselves. With these staffing problems, even more pressure has been placed on the more capable direct care staff.

**Response:**

Mr. Appel was instructed to provide close supervision to any staff that may be in the aforementioned category. Indeed this close supervision may have been the contributing factor to several employees resigning. The management of the facility will continue to work closely with employee development

- **Unabated for 30 Days or More:** The Department committed to a remediation plan in January of this year to: replace the vitreous china fixtures with stainless steel in no less than two bedrooms immediately; replace the vitreous china fixtures with stainless steel upon any breakage or damage; and retrofit the remaining vitreous china fixtures with stainless steel within a three-year period. Though the Department asserts that a consultant has been hired to help determine how to begin to address the needed changes, none of the dangerous items has been replaced with a suitable fixture.

**Response:**

This item is still on the future maintenance planning and will be completed as funding becomes available.

- The toilet seats have had to be removed in the youths' sleeping rooms because of the risk that they will be used as weapons.

**Response:**

No response required.

- **Unabated for 30 Days or More:** Suicide proof beds still have not been secured to replace the current beds, which have tie off places for an attempted suicide.

**Response:**

The monitors are aware of the progress we are making on replacing the beds.

- **Unabated for 30 Days or More:** Pull out stools remain even though one youth attempted a suicide by using the stool support as a tie off point from which to attempt to hang himself.

**Response:**

There have been no changes to the maintenance plans.

- **Unabated for 30 Days or More:** Long sink handles remain in spite of two youth breaking off the handles and using them as weapons.

**Response:**

Several handles have been replaced and we will continue to replace them until all of the handles have been replaced.

- **Unabated for 30 Days or More:** Unsafe ADA rails present a danger to youth as they provide a potential tie off point for a suicidal youth and may be pulled off the wall as used as a weapon. The Department cites ADA regulations, but does not address the concern that these fixtures are dangerous, that alternative rails could be utilized, or that the current rails could be modified to make them safer.

**Response:**

The rails are on the maintenance list for modification.

- **Unabated for 30 Days or More:** The sprinkler heads are not tamper proof, as one youth succeeded in setting off the system.

**Response:**

The manufacturer's specifications for the lights that were installed at the WMCC state the following: Maximum security construction. One-piece housing, security lensing and tamper resistant fasteners to maximize impact resistance and prevent unauthorized fixture penetration. Ideal for confinement/security. Suitable for use in inmate cells, psychiatric wards, secure corridors and general population areas.

- **Unabated for 30 Days or More:** The light fixtures, like the fixtures in BCJJC, have proven to be breakable and used as weapons. These fixture problems need to be addressed as they present an ongoing danger to youth and to staff.

**Response:**

The light fixtures in the sleeping rooms are not identical to the ones at the Baltimore Center. Juvenile Justice

- **Unabated for 30 Days or More:** The facility is in need of some 20 additional video cameras. As of yet, there is no recording capability at all in the facility through any of the existing cameras.

**Response:**

IT is seeking funding for the cameras.

- **Unabated for 30 Days or More:** Tinting of the control room windows to provide confidentiality and safety has not been installed. This presents a breach of confidentiality of youth in the facility. A photograph demonstrating this breach has been submitted along with the monitoring report.

**Response:**

As stated in previous reports, it is on the list for modifications.

**Unabated for 30 Days or More:**

The locked doors in the facility are in danger of opening when there is a loss of power, as happened on one occasion. Series of doors should be placed on different circuits to avoid this potentially very dangerous situation from occurring again.

**Response:**

Please provide where this information is documented.

- **Unabated for 30 Days or More:** There is no security lighting behind the back fence of the WMCC, and the control monitor cannot detect whether or not there is a person present on the grounds behind the fence. Windows into the pods are visible from that area. Also, contraband could be slipped into the recreation area without being observed. Lighting should be added to this area to provide added security. This issue has been reported to the monitor as a concern of WMCC staff.

**Response:**

This recommendation is under consideration.

- **Unabated for 30 Days or More:** On two sleeping units, A and C, there is no perimeter fencing to prevent someone from the outside from walking up some of the youths' sleeping rooms. This presents a breach of confidentiality and privacy.

**Response:**

We are currently developing plans to correct this breach.

- **Unabated for 30 Days or More:** The evacuation area on the west side of the building has no fencing to separate youth from the furnace and the outside gate.

**Response:**

This fence would cut off the evacuation route between the gymnasium and the refuge area. This would result in those youth evacuating the gym being stranded in the area of the generator and chiller.

Not utilizing the gym exit door would result in youth exiting the building by initially traveling further towards the interior of the building and possibly towards the source of the fire.

- **Unabated for 30 Days or More:** It is the practice on ASSIST to begin the counting of a youth's time in the facility over each time the youth goes to court and returns under a different status. A youth may be at WMCC "pending a hearing" for a month or longer, go to court and return under the status "pending placement". At this point ASSIST would begin the count again, by listing his enrollment date as the date he returned under the new "pending placement" status. Also, it has been practice to begin the accounting of time over when a youth transfers from one detention facility to another detention facility. This procedure gives an inaccurate and deflated accounting of how long the youth has actually been continuously in detention. The practice is particularly vulnerable to abuse by the Department at this time as youth may be detained longer because funding for placement is not available in the DJS budget.

**Response:**

The facility maintains and updates

**The Lower Eastern Shore Children's Center (LESCC)** is a state owned and operated facility located in Salisbury, Maryland. The facility houses males and females between the ages of 12 and 18 years old. The facility operates under the DJS Detention Standards and other DJS policies and procedures. The facility is located on the grounds of the Wicomico County Adult Detention Center and shares its building with DJS transportation officers, electronic monitors, and the fiscal manager for the Eastern Shore.

- During this reporting period, three independent monitoring visits were conducted with DJS officials in an effort to work collaboratively to resolve the concerns of this Office.

**Response:**

No response necessary.

- **Unabated for 30 Days or More:** The 12-bed unit usually has two staff members assigned to work during the day and evening shifts. The two 6-bed units have single coverage. All units should have double coverage.

**Response:**

The Resident Advisor Supervisor position has been filled.

One Resident Advisor I position has been filed and the transmittals for the Recreation Supervisor I and three vacant Resident Advisor positions have been submitted to personnel. The transmittals were submitted 4/25/05 and 4/12/05.

- The facility had three group disturbances in January. On January 5<sup>th</sup>, five youth were involved in a physical altercation. While the youth were assaulting one another, the staff's two-way radios were not working. The facility still has not received a better quality two-way radio similar to the radios used at the Baltimore City Juvenile Justice Center. The staff recently received additional two-way radios purchased from a retail store that experience interference from outside of the facility. DJS has stated twice on Corrective Action Plans that they are awaiting FCC approval to purchase radios yet the staff continues to work in an unsafe environment.

**Response:**

Radios have been secured and will be operational in the immediate future. They will become operation on May 27, 2005.

- On January 15<sup>th</sup>, a group altercation in A and B pods required law enforcement to quell the disturbance. One youth refused to cooperate and was pepper sprayed by officers. On March 10<sup>th</sup>, youth from A and B pods were again involved in an altercation in the hallway after eating their evening snack. Every evening all youth are taken to the dining hall to receive their snack. The dietary supervisor stated that the evening snack could be served on the units to avoid youth movement in the hallways. With the shortage of staff, the extra movement and combining units in the dining hall leads to an unsafe environment.

**Response:**

Snacks will be eaten on the pods effective 5/9/05

- **Unabated for 30 Days or More:** This Office has cited the staffing shortage as a major concern for youth and staff safety. When disturbances occur on one pod, staff on the remaining two pods must lock their youth in their rooms before assisting with the disturbance. The delay in the response time causes a substantial risk for injury to the youth and staff.

**Response:**

We are continuing to recruit and hire Resident Advisors.

- The superintendent has responded to staff concerns of the unsafe environment by stating the LESCC is a Level 5 maximum security facility and staff should have never allowed themselves to feel as if they were comfortable. He stated that the Carter Center is a Level 4 facility. This Office is unaware of different levels of security within Maryland detention facilities and; therefore, respectfully requests a copy of the classification requirements for such.

**Response:**

There may be some confusion. All Detention Facilities are Secure Confinement Facilities that are considered High Risk. The Level system has not been instituted for detention. .

- The shift supervisor is often assigned to work on a pod or in the control center and is unable to properly monitor the performance of the staff. During the March 10<sup>th</sup> fight, the shift supervisor had to leave the control center to assist her staff in breaking up the disturbance. Due to the lack of direct care staff in the building, the female dietary worker was required to operate the control center until the incident was resolved.

**Response:**

Since 4/1/05 All Resident Advisor Supervisors are only in coverage, when there is a call out and staff are short handed. This is appropriate to provide adequate coverage.

All staff can be trained to operate the control center on a temporary basis.

- The staffing shortage also creates other concerns. Many times, staff are unable to take fifteen- minute breaks during their eight-hour shifts because no relief staff is available. During the March 11<sup>th</sup> visit, this monitor witnessed one male staff member in the parking lot smoking a cigarette. Upon entering the facility, the staff member went back to A Pod. Before leaving his unit unattended, he had locked the two seclusion youth in their rooms while he left the building to smoke. No staff was on the unit with the youth the entire time he was outside. This monitor notified DJS Headquarters of this incident and the staff members were disciplined. However, the issue of not having a process or adequate staffing to provide staff breaks has not been addressed.

**Response:**

As positions are filled, this matter will be resolved.

- This monitor, during a March visit, suggested to the staff that they should not mix seclusion youth with other youth during their 1-hour recreation. Within the hour, a seclusion youth and another youth assaulted each other on A Pod. To date, the incident has not investigated by OPRA even though this monitor reported it to DJS Headquarters, nor has an incident report been filed documenting the incident as required by DJS policy and procedure.

**Response:**

The procedure has been changed to allow the Recreation Specialist to take seclusion youth to recreation at different times.

- Four youth were held seclusion for twenty-four hours after assaulting other youth. This monitor observed the seclusion checklists for the 7am to 3 pm shift and the youth were found to be sleeping, walking, eating, or standing at door. There were

no comments citing disruptive behavior requiring continued seclusion. Because the youth were no longer considered an imminent danger of physical harm to themselves or others, escape, or destruction of property, they should have been released from locked door seclusion.

**Response:**

Procedures will be developed to monitor the use of seclusion and to ensure the appropriateness of its use.

- **Unabated for 30 Days or More:** On the January 2005 monitoring report, this monitor cited the excessive flooding of the toilets in the facility. This monitor has learned that until recently, all three units had to share one key to the doors that lead to the area to turn the water off. Some staff were unsure which pod had the key and not all staff knew how to turn the water off. Training is needed for all staff to be able to turn off the water during an emergency. Also once the water is off, youth are still able to continue flushing the toilets until toilet is empty.

**Response:**

Staff will be made aware of the need to turn water off if youth begin to tamper with their toilets.

- Youth are not being searched each time they enter the Pods as required by policy and detention standards. This may be why many incidents have occurred with weapons on the housing units.

**Response:**

Youth will be searched before entering the living areas, effective 5/9/05

- The facility does not have a policy addressing when law enforcement assistance shall be requested and on law enforcement's use of pepper spray/mace on youth. Because the Pods are small and do not have outside airflow, the pepper spray/mace could affect the other youth on the pod. The policy might address whether youth who are not involved in the crisis requiring law enforcement assistance should be evacuated from the pod and where should they be placed. The policy might also address the medical staff's role in assisting the youth.

**Response:**

A procedure will be developed for the facility concerning when the police are called.

- The facility does not have a Recreation Coordinator. Two coordinators were hired in the past year although one resigned after working only a short period. The second coordinator was terminated shortly after his start date.

**Response:**

A Transmittal sent for the position on the person selected on 4/25/05.

- **Unabated for 30 Days or More:** The facility lacks an enhanced evening programming schedule. Since January, the case manager has provided some evening programming to the youth. However, the addictions counselor only works day hours so the youth do not receive substance abuse counseling as part of the evening program.

**Response:**

We will implement and develop additional programs like NA and AA for the evenings

- The facility was designed to provide life skills training to the youth. The life skills room is equip with a kitchen for cooking projects but cannot be utilized because the sink does not work.

**Response:**

The water has been turned off to keep the youth from turning on facet on during the school day. It is not in need of repair.

- The control center still does not have the ability to monitor the entire intake area by camera. A camera is also needed in the classrooms.

**Response:**

Cameras for the intake area were installed on 8/3/04.

Cameras may need to be pan and tilt type as the monitor thinks the cameras are not viewing enough area. Cameras for the class rooms were requested in Aug, 2004.

- **Unabated for 30 Days or More:** As cited in previous monitoring reporting, the youth continue to receive less than the required five hours of schooling per day.

**Response:**

We are currently interviewing candidates to hire a special education teacher for the facility, a vacancy that has existed for nine months.

On May 25, 2005 a meeting will be held with the teacher supervisor at the facility to discuss re-organizing the school schedule, which may involve having male and female students attend school together. I will also meet with education staff, Mr. Smith and the facility superintendent to identify a plan for an appropriate school schedule that complies with the length of the school day requirements. The schedule should be implemented by June 6, 2005.