JUVENILE JUSTICE MONITORING UNIT'S ASSESSMENTS OF FACILITIES AND THE DEPARTMENT OF JUVENILE SERVICES RESPONSE

FACILITY	LOCATION	Page#
Baltimore City Juvenile Justice Ctr	Baltimore City	1-8
Charles H. Hickey, Jr. School	Baltimore County	8-16
MD Youth Residence Ctr	Baltimore City	17-19
Sykesville Shelter Care Facility	Carroll County	19-20
Thomas O'Farrell Youth Ctr	Carroll County	20-24
Allegany Girls Group Home	Allegany County	24-26
Youth Centers	Allegany County	26-32
William Donald Schaefer House	Baltimore County	32-36
Alfred D. Noyes Children's Ctr	Montgomery County	36-40
Western MD Children's Ctr	Washington County	41-45
Cheltenham Youth Facility	Prince George's County	46-48
J. DeWeese Carter Children's Ctr	Kent County	48-51
Lower Eastern Shore Children's Ctr	Wicomico County	51-53
GUIDE-Catonsville Structured Shelter	Baltimore County	53-54
Mount Clare House	Baltimore County	54
Thomas J.S. Waxter Children's Ctr	Anne Arundel County	54-56

Juvenile Justice Monitoring Unit
Central Area Quarterly Report for Jan – Mar 2006

THE BALTIMORE CITY JUVENILE JUSTICE CENTER (BCJJC) is a State detention facility that has the capacity to *safely* house 72 youth; however, once a suicide resistant barrier is constructed for the second tier, the facility will be able to safely house its designed capacity of 144 youth. The Maryland State Department of Education provides instruction to the youth at the facility.

STAFFING:

- Population explosion:

There has been a significant increase in the population at the facility. The facility is rated for a maximum population of 144 and although DJS data indicates the population averaged approximately 130 during the quarter, this monitor observed populations at or exceeding 150 on at least seven occasions during the quarter with a maximum of 158 on 2/10/06. Stack-a-bunks are often being utilized for sleeping. Administration advised that the facility utilizes the infirmary, intake area, interview room and open area of the unit for sleeping up to 24 extra youth and would use the gymnasium if it became absolutely necessary.

DJS administrators are looking for relief in population numbers when a secure 48-bed facility is re-opened at Victor Cullen in Frederick County.

- Staff/Youth Ratios:

This monitor observed the population to be between 119 and 158 youth throughout this quarter. Supervisory and direct care staff report that field services staff are being used to supplement direct care staff during visiting days and special events to maintain the direct care staffing ratio of 1:6. On 1/19/06, eight (8) staff persons were either held over or brought in early on overtime to maintain the 1:6 staffing ratio.

- Staff Training:

Child Abuse Recognition and Reporting Training:
This monitor spoke with the training coordinator for the facility and she has agreed to provide dates for entry level and in-service training.

Unabated for 30 or More Days:

- Child Abuse Interagency Agreement and Restraint Training:

Although it was agreed upon during meetings with DJS, police and Child Protective Services on August and October of 2005, there is still no agreement in effect and no trainings have taken place for DSS, DJS and Police investigators relating to the proper use of restraints in DJS facilities. To facilitate and expedite the observation of Crisis Intervention and Restraint Training this monitor continues to recommend that the appropriate investigators from DSS, DJS and MSP observe the trainings during the restraint training that is provided to entry-level DJS employees.

Response:
The Department is in compliance with the law that prescribes how each agency is to handle youth. In addition, we are in the process of having all of the agencies involved sign the MOU that has been developed.

- Staff Incentives:

Although many staff persons are severely overworked, administration has put several incentives in place to attempt to boost morale. Staff persons are being promoted from within the facility whenever possible. Three of the next four supervisory vacancies are being filled with existing staff. Six contract positions were recently converted to permanent positions, which will provide more benefits and security to employees. Staff are recognized as "Staff of the Month" and provided a plaque and parking space.

Response:
Why is this considered unabated? What is the issue?

- Identification and Professionalism:

In the event that a staff person's identification is necessary by staff, monitors or youth, it is difficult to determine without asking other staff and/or compromising privacy. Some type of name tag should be worn so staff persons are immediately identifiable. This would also be a more professional way of identifying staff.

Response:
This was identified in the current reporting period. It has been corrected and it is not over 30 days unabated. This appears to be the opinion of the monitor and a non-issue.

SAFETY AND SECURITY:

Unabated for 30 or More Days:

- Detention/Pending Placement Youth:

This concern has been cited repeatedly since the facility opened in October of 2003. Youth are only supposed to be "detained" for a period of 30 days prior to their adjudication hearing. Youth who have been adjudicated and are awaiting placement should be placed within 60 days from their date of commitment. Numerous youth are held in detention and pending placement beyond those time limitations set by law. A meeting with DJS administration on 3/29 revealed that DJS is aggressively pursuing placements in community based and wrap-around programs; however, evaluations concerning education, somatic/mental health, substance abuse and family/social/delinquent history often expose high risk factors that might jeopardize the community. DJS is reportedly working with other State agencies (DSS, DHMH and MSDE) in an effort to address the problem with finding placements for these youth and develop a single point of entry into the system.

DJS is also conducting a 2-month review of youth who are on pending placement status in an effort to streamline the relationship between a youth and his case manager. The integrity of the case management process is being studied and case managers assigned to youth will reportedly remain assigned to a particular youth regardless of where the youth might be placed.

- Mental Health Youth:

A youth with an IQ below 60 was observed at the facility on 2/10/06. As stated above, DJS says they are in the process of trying to work with DHMH for appropriate placements.

Unabated for 30 or More Days:

- Aggressive Incidents:

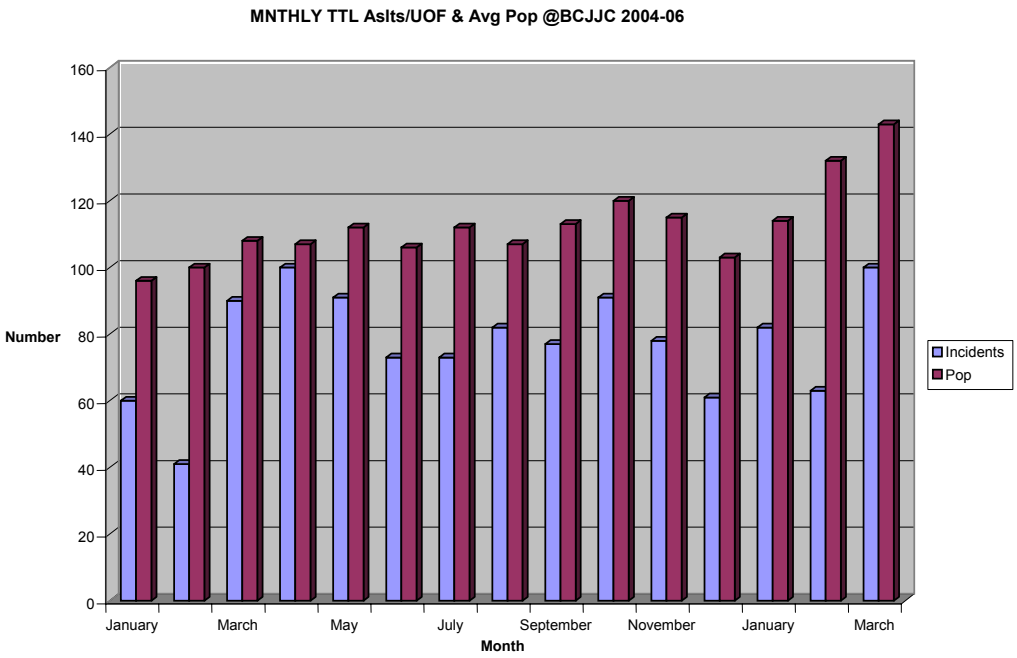
This concern has been cited repeatedly since the facility opened in October of 2003. The daily population at the facility averaged around 130 youth and the numbers of aggressive incidents (youth on youth assaults, staff assaults, child abuse and use of force incidents) fluctuated but rose consistently with the increase in population. Youth must be kept safe.

According to the DJS Incident Report database, the following incidents have been reported at BCJJC from 2004 through 2005. Also included is the average monthly population obtained from DJS:

	Y on Y Aslt/Riot	Y on S Aslt	CHAB	UOF	**TOTALS**	Avg.# 0f Assaultive Incidents Per Day	Avg Pop
January	36	3	0	21	**60**	**1.9**	96
February	30	2	1	8	**41**	**1.5**	100
March	52	18	1	19	**90**	**2.9**	108
April	55	15	0	30	**100**	**3.3**	107
May	47	19	1	24	**91**	**2.9**	112
June	43	12	0	18	**73**	**2.4**	106
July	41	17	0	15	**73**	**2.4**	112
August	47	11	0	24	**82**	**2.6**	107
September	45	4	0	28	**77**	**2.6**	113
October	39	14	0	38	**91**	**2.9**	120
November	39	4	0	35	**78**	**2.6**	115
December	34	7	1	19	**61**	**2**	103
January	39	7	0	36	**82**	**2.6**	114
February	36	4	0	23	**63**	**2.3**	132
March	50	10	0	40	**100**	**3.2**	143
TOTALS	**633**	**147**	**4**	**378**	**1162**	**2.54**	**113**

Key: Y on Y Aslt = Youth on Youth Assaults; Y on S Aslt = Youth on Staff Assaults
CHAB = Sexual and Physical Child Abuse Incidents; UOF = Use of Force

The following graph is based on the above information:



It should be noted that although the population has been steadily increasing, the number of reported aggressive incidents did decline in February, but rose again in March.

- Peer mediation:

See information below under Programming

- Use of Seclusion:

Youth are being placed in a special unit (Unit 23) for seclusion and social separation during school hours. On 1/19/06 at 10:00 AM, there were 2 youth on social separation and 12 youth in seclusion on Unit 23.

Response:
The Superintendent disputes this allegation that youth are being placed in a special unit for seclusion. An investigation was conducted by OPRA and they agree with the Superintendent.

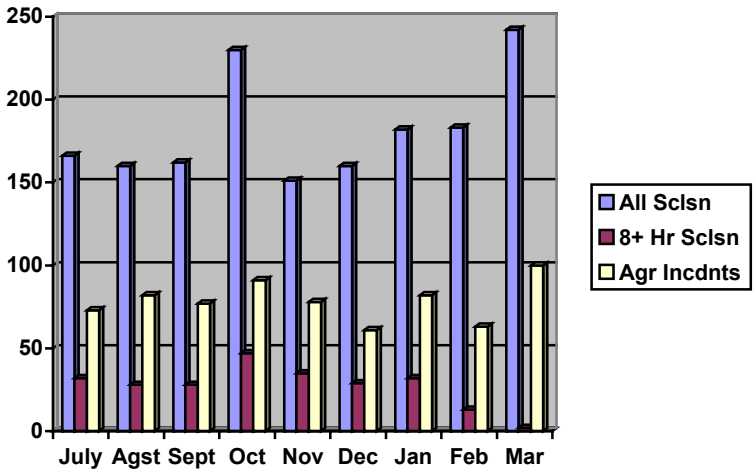
Use of seclusion remains high, although there appears to be no effect in reducing the number of aggressive incidents as indicated above.

According to the Seclusion Log in Master Control, there were:

- 230 reported incidents for the use of seclusion in October,
- 151 in November
- 160 in December through 12/28/05
- 182 in January, 2006
- 183 in February
- 242 in March
- The figures for this quarter (Jan – Mar) average out to almost 7 incidents of seclusion every day.

Reported incidents of youth being placed in ***locked door seclusion for more than 8 hours*** (ICAU Incident Report Database) declined drastically from 111 last quarter to 47 this quarter. To determine the effect of seclusion on the number of assaults and aggressive

type incidents see the following chart. The following chart indicates the number of **All Seclusions (including less than 8 hours)**, **Locked Door Seclusion for More than 8 hours** and **Aggressive Type** incidents that have been entered in the Seclusion Log and ICAU Incident Report Database for July 2005 through April of 2006.



Unabated for 30 or More Days:
This concern has been cited repeatedly since a Special Timely Report was submitted by this Office in March of 2005.

- It appears that although the use of 8+ hour seclusion steadily declined and the population steadily increased from January to March, the number of aggressive incidents fluctuated. The use of seclusion alone cannot be deemed effective for reducing violent/aggressive incidents. The facility should be commended for reducing the number of reported incidents for 8+ hour seclusion; however, the increase in all seclusions indicates a need for more effective crisis intervention.

Unabated for 30 or More Days:
This concern has been cited repeatedly since the facility opened in October of 2003.

- Suicide Gestures:
  On 1/24/06, a youth tied one end of his bed sheet to the second tier railing and staff pulled the sheet away from the youth to prevent him from placing it around his neck (See Incident Report Number 35888). On 3/24/06 another youth ran to the second tier, tied clothing around the railing and was subsequently stopped by staff before he could hang himself (See Incident Report Number 37515).

  There is still no suicide resistant barrier on the second tier of the facility, although the facility administrator and this office have repeatedly requested that the railings be encased. A DJS memo from 1/29/06 indicated that the Department of General Services (DGS) was "soliciting the project."

- Illegal Paraphernalia and Weapons:
  There has been a significant rise of incidents involving the possession of illegal contraband in the facility. There were 5 incidents last quarter and there were 15 this quarter. One incident involved the possession of a homemade shank that consisted of a sharpened wire wrapped in cloth (Incident Report Number 37316). Staff discovered the contraband during routine searches of the youth's rooms.

Response:
Most of our efforts are focused on deterring contraband and we plan to be vigilant in continuing to address this issue. It should be noted that the contraband was discovered during the facility routine shakedown. It is reasonable to note that shakedowns are conducted as normal operating procedures, which sometimes occur daily. It is not unabated for 30 days when staff provide the services necessary to discover the contraband. Discovering contraband also demonstrates how we have increased our searches and shakedowns.

- Incident Involving the Front Door of the Facility being Shot Out:
  DJS Incident Report Number 36007 indicated that the front door of the facility was shot out on 1/28/06; however, an investigation by the Maryland State Police and DJS failed to reveal any evidence that indicated the window was destroyed by a bullet or any other projectile.

- Fire Drills:
  According to logs, the drills are being completed every couple of weeks even though they are only required once a month. A Fire Marshal's inspection is not due until September.

- Master Keys in the Event of a Fire:
  Shift Commanders carry master keys with them that are extra large for easy identification in the event of smoke or other problems that might prevent visual identification of the key.

EDUCATION:

- Classroom Overcrowding
  Some of the staff from MSDE expressed concern that the population has risen to 20-plus in some of the classroom periods. This crowding problem will be partially addressed when the second floor is renovated for the education department; however, more teachers are still required to meet the needs of this population. Some of these concerns should be addressed when the second floor of the facility is renovated to accommodate education.

- Vocational Program:
  This monitor observed an excellent vocational program for drafting and electronics. The program incorporates both manual and computer based techniques used for measuring, drawing and designing particular projects. The teacher advised that the youth attending the classes have been very engaged.

PROGRAMMING:

- Performance Based Standards:
  The facility is participating in the Performance Based Standards program through the Council of Juvenile Correctional Administrators and the Department of Justice Office of Juvenile Justice and Delinquency Prevention. As a result of data that is fed into the system and analyzed, recommendations are made for facility improvement in compliance with national standards.

- Token Reward/Levels System
  Administration advised that youth earn tokens for good behavior each day and they can use the tokens to purchase lotions, candy, movie nights, extra recreation, extra phone time, extra bedtime, extra visitation and video games. If a youth's behavior requires seclusion or room separation, his use of the tokens is postponed but he does not lose the tokens he has accumulated. It is also possible for a youth to earn top level privileges in just seven days.

- Peer Mediation:
  Administration advised that a peer mediation process is being developed through a representative of the Maryland Administrative Courts. Four staff persons and twelve youth will be trained to mediate peer disputes.

- After School and Weekend Programming:
  Supervisory staff advised that daily programming has been improved but they felt more consistent evening and weekend programming is needed to keep the youth engaged.

HEALTH/MEDICAL:
No significant concerns in this area.

FACILITY AND MAINTENANCE:

Unabated for 30 or More Days:
This concern has been cited repeatedly since the facility opened in October of 2003.
- Lack of a suicide resistant barrier on the second tiers.
  There is still no barrier to prevent youth on the second tiers from attempting to hang themselves.

Unabated for 30 or More Days:
This concern has been cited repeatedly since the facility opened in October of 2003.
- There is still no barrier between food service personnel and the youth in the serving line in the dining hall. Youth could easily leap over the counter and assault staff.

- Carpeting needs to be replaced on several units.

ADVOCACY, INVESTIGATIONS AND MONITORING:
- Grievances:
  The DJS Child Advocate advised that he handles approximately 4 to 5 written grievances per month and the number of informal grievances (verbal) that are handled is determined by the number of verbal grievances the advocate has time to listen to. The wood and plastic grievance boxes that were on the units were continually being destroyed by the youth so a metal pass-through drawer has been placed in the wall on each unit to collect the written grievances.

Unabated for 30 or More Days:
This concern has been cited repeatedly since the Quarterly Report was submitted for the quarter July through September of 2005 but there have been no grievance summaries received by this Office since the facility opened in October of 2003.
- This monitor has not received any DJS grievance summaries from ICAU this quarter.

Response:
The Monitoring Unit is provided with or given access to every grievance generated by the department. We have continually noted that there is no grievance summary document completed by ICAU that can be submitted to the monitor. The monitor does receive copies of all incidents and grievances as required by the MOU.

- Investigation Processing and Reporting:
  According to the Assistant Director of the DJS Office for Professional Responsibility and Accountability (OPRA), there was a review during the month of February concerning the questionable restraint incident that occurred on 7/7/05 (ICAU Incident Number 30943), which resulted in a youth reportedly losing consciousness. The incident was reportedly reviewed by a trainer with the DJS Office of Professional Development and Training (OPDT); however, the Director of OPDT was not aware of the incident review. According to the Asst. Director of OPRA, the reviewer stated that the restraint did not appear abusive but the technique that was used was not entirely proper. DJS has agreed to mandate attendance to crisis intervention and restraint training for all facility administrators.

Unabated for 30 or More Days:
This concern has been cited repeatedly since a Special Report was completed by this Office in March of 2005.

- Child Abuse Investigation Interagency Agreement:
  A written interagency agreement must be developed for responding to child abuse and major incidents at the facility.

Response:
We are in compliance with the law as it relates to Child Abuse Investigations. The monitor is aware; the department has been meeting with all agencies to develop the Interagency Agreement. The Agreement is in the final stages of completion and we are reviewing final comments.

THE **CHARLES H. HICKEY SCHOOL** is a State owned and operated detention facility that currently has two cottages that are supposed to be dedicated to detention and one cottage dedicated to pending placement. All three cottages are located behind a razor wire fenced in area. The Maryland State Department of Education provides instruction to the youths at the facility. This monitor conducted five (5) unannounced visits per the standard operating procedure between this Office and DJS.

STAFFING:

- Population:
  The number of youth in detention has increased from an approximate average of 70 youth during last quarter to approximately 85 youth during this quarter; however, DJS administrators are diligently attempting to maintain a staff to youth ratio of 1:6. Staff are often drafted to work overtime and staffing requirements also become stressed to meet one-on-one requirements for youth who are suicidal or who require special attention. The population was observed as 74 in January, 91 in February and 97 in March. On 2/14, 6 youth had to sleep in the infirmary due to overcrowding.

Unabated for 30 or More Days:

- Placement of Youth:

This concern has been cited repeatedly since the State removed the Impact and Intermediate programs in October of 2005.

The numbers of post adjudicated youth in detention waiting for placement rose from a monthly average of 28 throughout last quarter to a monthly average of 45 throughout this quarter. Several youth advised this monitor that they had been at the facility awaiting placement for more than 60 days and two youth advised they had been in pending placement status for 6 months. A review of the pending placement population list corroborated those concerns.

There is a problem with finding appropriate placements for youth throughout the State. DJS administrators met with this monitor and discussed plans for opening a 48 bed facility at Victor Cullen in Frederick County and ongoing attempts to involve other agencies such as DSS and DHMH with help in placing youth. DJS is also reportedly trying to develop clinical and educational positions to coordinate staffings with DHMH and MSDE respectively. DJS also continues to pursue placement options with private organizations that are on contract with DJS.

DJS administration is in the process of analyzing pending placement cases to determine some of the internal problems with supervision and case management to try and develop a more efficient process in maintaining a consistent link between the youth and their case managers. Administrators advised that there is more emphasis for the youth's DJS case manager to remain with the youth throughout their intake, detention and placement process.

- Space for Facility Case Managers:

On 2/14/06, this monitor observed four facility case managers crowded into one room on Clinton Hall with only 1 phone and 1 computer available for their use. Each case manager was trying to conduct an interview with youth from their assigned caseloads and there was no sense of privacy or professionalism. Administration explained that there would be more room for case managers when some were moved to the orientation unit on Ford Hall, which was supposed to become operational by the end of February; however, Ford Hall was not operational throughout the entire quarter. Case management staff must have privacy and access to appropriate resources to address the needs of the youth on their caseloads and to provide a professional work environment.

Unabated for 30 or More Days:

- Staff Misconduct:

This concern has been cited repeatedly since the State took over the facility in March of 2004.

- Several cases of misconduct are identified in the child abuse area of this report.

- A DJS Incident Report (36402) identified a situation where a youth reported it was necessary to urinate in a cup in his room during evening hours because staff persons were slow to respond to bathroom needs. Administrative staff subsequently issued a directive to reinforce procedures and make sure staff persons were responding in a timely manner to youth's needs to go to the bathroom at night.

- It was reported by several staff persons that some supervisors at the facility are not professional and need additional training. The staff persons said that many supervisors use profanity and show favoritism with both youth and other staff.

Response:
Anonymous reports staff considered not professional is unacceptable. What exactly does the monitor mean when they indicate that staff are "not professional?" Names of the staff the monitor observes should be reported to the appropriate administration during the exit interviews. In addition, staff training at the facility is ongoing. All staff are required to participate in forty hours of training each year. If there is a need for specific training in professionalism, the training will be developed.

- On 3/9/06, ICAU Case Number 37140 reported that a staff person was arrested for domestic related charges.

Response:
This situation, while unfortunate was handled in the appropriate manner using the Standards of Conduct and Disciplinary Process.

- Some staff persons are stopping their vehicles in the roadway at the entrance to the facility making it necessary for other vehicles to drive around them and interfere with other vehicles attempting to exit the facility. On 3/28, this monitor observed traffic entering and exiting the facility from 2:15 PM until 2:30 PM and at one point 5 vehicles were stopped behind one another in the roadway while staff walked up to the gatehouse to check themselves in for work.

Response:
Please be aware that this is a public document and it will inform every reader of the shift changes at this facility. In our opinion, this statement jeopardizes the safety of the staff and the youth at the facility. Staff will be directed to park first then enter the facility gatehouse for duty.

SAFETY AND SECURITY

According to the DJS Incident Report database, the average number of assaultive incidents per day decreased from 1.5 per day during last quarter to1.4 per day during this quarter. The decrease may be considered more significant considering the rise in population.

The source data for the following chart was extracted from the ICAU/DJS database and encompasses April 2005 through March 2006 for a 12 month comparison. It must be noted that some of these incidents have resulted in child abuse/neglect investigations that are not accurately reflected in these totals:

	Y on Y Aslt	Y on S Aslt	CHAB/Nglct	UOF	**TOTALS**	Avg.# 0f Assaultive Incidents Per Day
April	26	8	0	32	**66**	**2.2**
May	34	13	0	37	**84**	**2.7**
June	26	13	1	21	**61**	**2**
July	25	7	0	25	**57**	**1.8**
August	31	9	0	26	**66**	**2.1**
September	22	13	1	10	**46**	**1.5**
October	36	9	1	19	**65**	**2.1**
November	16	11	0	15	**42**	**1.4**
December	13	0	0	16	**29**	**0.9**
January	28	4	1	21	**54**	**1.7**
February	13	2	0	6	**21**	**0.8**
March	28	3	0	19	**50**	**1.6**

Key:
Y on Y Aslt = Youth on youth assaults; Y on S Aslt = Youth on staff assaults
CHAB/Nglct = Child Abuse and Neglect investigations; UOF = Use of force

Child Abuse and Neglect Cases:

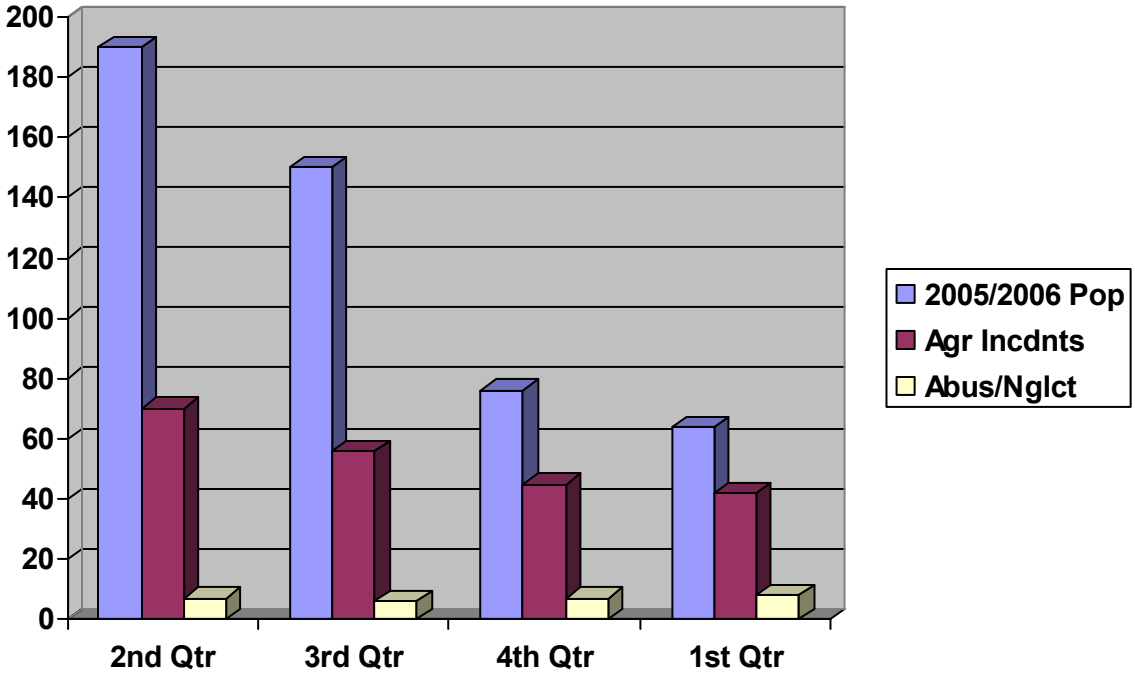
There were six (6) physical abuse and neglect reports accepted for investigation by DSS last quarter and there were eight (8) reports of physical abuse accepted by DSS this quarter.

- One investigation resulted in two staff being disciplined for not monitoring youth activities properly and not sending a youth to the hospital as required by procedures.
- Another abuse investigation resulted in staff being terminated and criminally charged with assault. The staff was also indicated for physical abuse.
- One other investigation resulted in the identification of a hazard in the gym floor area and a recommendation from the DJS investigator that repairs be made – which they were.
- It has also been discussed with investigators that youth who make false allegations of abuse should be criminally charged with making a false report of a crime.

This monitor has 3-month data from the Child Abuse/Neglect cases reported to the Department of Social Services as follows:

January: 4 Physical Abuses
February: 2 Physical Abuses
March: 2 Physical Abuses

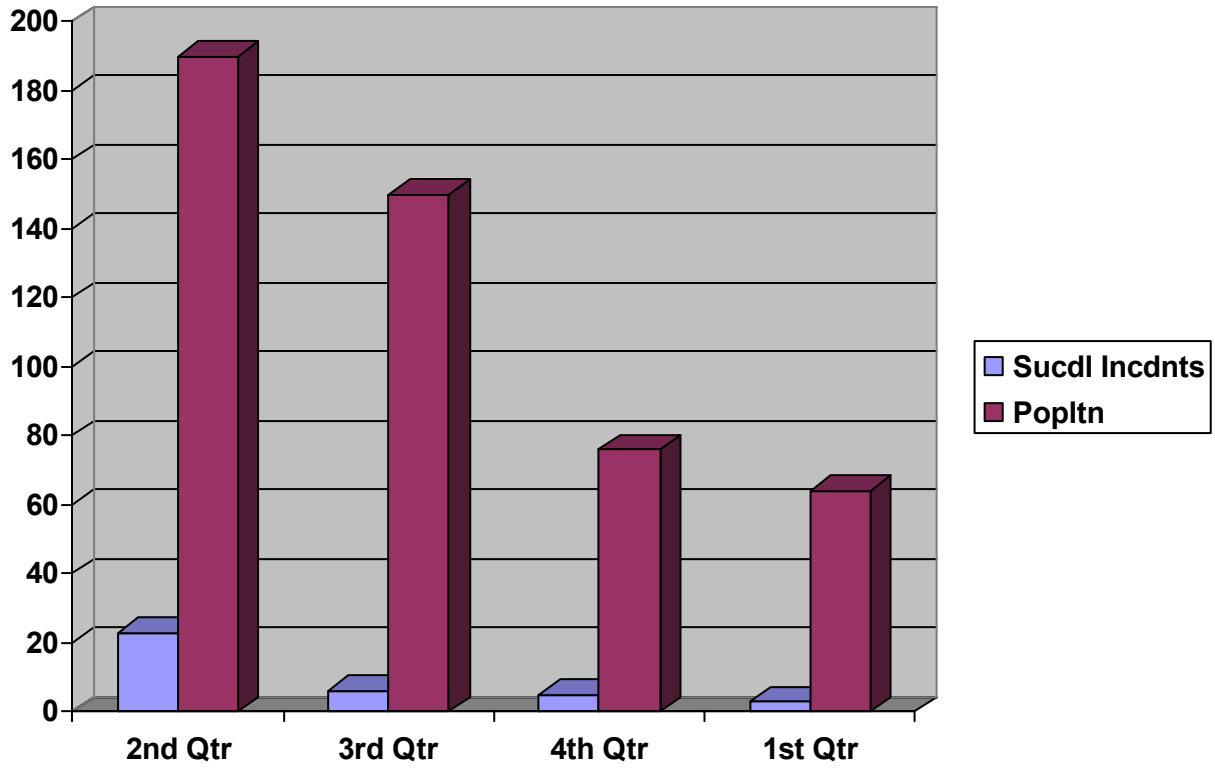
The following chart compares the number of aggressive incidents (Agr) per quarter from April of 2005 through March of 2006 with the average monthly population (Pop) during that same time period. The number of child abuse/neglect reports (Abus/Nglct) investigated by CPS during the quarter are also recorded. However, it must be noted that the although the average monthly population decreased from last quarter to this quarter, it increased significantly throughout the quarter. The average monthly population rose from 68 in January, to 90 in February, to 96 in March, with half of those numbers in March representing youth in pending placement.



Unabated for 30 or More Days:
This concern has been cited repeatedly since the State took over the facility in March of 2004.

- Restraints and Use of Force
  There was one incident where a youth received a broken leg as a result of a restraint by several staff (ICAU Number 35487). A joint investigation by the State Police, DSS and DJS failed to reveal any criminal conduct or improper activity by staff; however, it must be emphasized that staff are responsible to ensure the safety of the youth under their care. DJS administration has agreed to ensure that all facility administrators are trained in the crisis management/restraint procedures utilized by direct care staff.

- Suicide Incidents:
  Suicide behaviors, attempts, gestures and ideations have continued to decrease. There were 5 last quarter and 3 this quarter. The following chart compares the number of suicidal incidents for the past 4 quarters with the observed population during visits that month.



- Hole in Fence:

According to DJS Incident Report Number 37142, a hole was discovered in the perimeter fence on 3/9/06. According to staff, no alarm sounded. It was not determined who created the hole or when it was created; however, the hole was subsequently repaired by maintenance personnel. Other problems with the alarm system are noted in the Facility Maintenance section of this report.

Response:
The hole in the fence was discovered on 3/9/06. The hole was repaired immediately. There is no indication that the repair was more than 30 days.

- Seclusion and Youth Accountability:

Seclusion was used 55 times in January, 32 times in February and 55 times through March 28. There does not appear to be any problem with excessive use of seclusion; however, according to staff and administration, seclusion is normally not used for any longer than 2 hours regardless of the reason youth has been placed there. Some staff feel that youth are not being held accountable for their actions and some are being released from seclusion while they are still a threat to other youth or staff. DJS administrators agreed that some youth may need to remain in seclusion for longer than 2 hours – depending on their amenability to being processed back into the facility population.

EDUCATION:

- Education staff reported that the youth are doing well in the program. The staff also stated that the DJS direct care staff were more responsive and cooperative in dealing with inappropriate behavior than they had been in the past, but they also felt some of the staff still needed to be more professional.
- Some of the education staff expressed frustration that the classes were becoming more and more crowded due to an increase in population and neither DJS nor MSDE are addressing the need for more teachers and/or space. The school and staff were originally established to teach 48 youth from two detention cottages but the population has swollen to more than 90 without additional considerations to provide more staff.

PROGRAMMING:

- Staff report that although intramural activities have been increased, the high numbers of youth make it difficult to implement effective after school or weekend programming.

HEALTH/MEDICAL:

- Some medical staff persons are not attaching body sheet diagrams to the medical report prepared for submission with the incident report. See report numbers 37549, 37486 and 37437 for examples.

FACILITY MAINTENANCE:

Unabated for 30 or More Days:

- The interior pedestrian sally port gate was not functioning throughout the monitoring period. This concern has been cited repeatedly since the State took over the facility in March of 2004.

Response:

The interior pedestrian sally port gate continues to be repaired as soon as it becomes inoperable. This gate is old and continues to break down. At the time of this response, the gate sally port gate has been replaced.

- The security cross arm that controls traffic exiting the facility was not working properly.

- There were ongoing problems with the fire alarm system in the gatehouse area of the facility. On 1/20/06, the alarm was continually sounding in the gatehouse. Staff advised it had been going off for several days and no one knew how to reset the alarm.

- On 2/14/06, there was a large amount of snow that had been ploughed and it was blocking the walkway adjacent to the gatehouse area, which led from the sally port to the paved roadway leading to the detention area. Staff persons were forced to walk around the snow and they were creating a large amount of mud in the unpaved area next to the gatehouse. This monitor notified Hickey administration and the snow was removed from the blocked walkway area.

Response:
The snow could not have been unabated for more than 30 days. The large amount of snow as indicated by the monitor was removed immediately upon notification.

ADVOCACY, INVESTIGATIONS AND MONITORING:

Unabated for 30 or More Days:

- Grievance Summaries: This concern has been cited repeatedly since the Quarterly Report was submitted for the quarter of July through September of 2005.
  This monitor has not received any recent monthly grievance reports pursuant to the Standard Operating Procedure developed between this office and DJS.

Unabated for 30 or More Days:

- Investigation and Report Processing:

This concern has been cited repeatedly since the State took over the facility in March of 2004. There are still concerns with investigators from DJS, MSP and DSS communicating during child abuse investigations.

- A Baltimore County DSS multi-disciplinary case review was conducted on 3/30/06 and it revealed that a suspected child abuse had reportedly occurred on 2/8/06 and according to the DJS incident report (ICAU Number 36377), the State Police were notified at 9:00 PM that same day.
- The police responded but took *no report* of the incident and determined there was no crime committed; however, the alleged victim had been seen by a nurse, the nurse's report indicated the youth's allegations that he was choked by staff and there were injuries consistent with the alleged abuse, which required medical assessment/treatment at a hospital.
- Although the police did not continue their investigation, a DJS investigator responded to the incident on 2/10 and he conducted a very thorough investigation that resulted in administrative charges against staff.
- DSS did not respond until 2/14; however, their investigation was very thorough and resulted in a "ruled out" finding.
- Suspected staff was removed from having direct contact with youth pending results of the DJS/DSS investigations.
- Staff returned to duty when DJS/DSS completed their investigations in the beginning of March but the staff was removed from direct contact again when the State Police restarted their investigation at the end of March.
- The Maryland State Police returned to Hickey on 3/28 to conduct a follow-up investigation just prior to the multi-disciplinary meeting. On 3/28, this monitor observed the police investigator at the scene and asked why the investigation had not been conducted with DJS and DSS and the investigator said he did not see any injuries on the youth on 2/8 and he did not think there was any abuse. He was unaware of any further follow-up investigation being conducted by DJS and DSS until he was notified to return to the facility on 3/24. The police investigator was not familiar with the nurse's report or the photographic evidence of the injuries.
- The police routinely presented their case at the multi-disciplinary meeting and were not familiar with the nurse's report or the fact that this monitor was aware that no report or follow-up investigation had been completed prior to 3/28.

The Baltimore County Interagency Agreement on the Investigation of Child Abuse and Neglect at the Charles Hickey School makes it very clear that, "DSS and MSP

shall immediately share with each other all information… [and] both parties shall notify the Independent Juvenile Justice Monitor and DJS …" The Agreement goes on to say that, "DSS and MSP shall conduct joint investigations of suspected child abuse to the fullest extent circumstances permit…"

Child abuse training was offered to the police at the meeting to ensure compliance with the requirements in the law, administrative procedures and the written Memorandum of Understanding. All police officers responding to investigate complaints of abuse at the Hickey facility must be familiar with the reporting/investigation requirements.

Also, once DJS is made aware of an allegation, it must ensure that cooperative efforts exist between all interested agencies.

Unabated for 30 or More Days:
This concern has been cited repeatedly since the State took over the facility in March of 2004.

- Late/Inaccurate Reporting:
  - Another report of suspected abuse that reportedly occurred on 3/15 was received by this monitor on 3/20. An immediate review of the DJS ICAU database failed to reveal that any report of the incident had been made. On 3/24, there was still no report in the database but a DJS investigator advised that the case had been entered on 3/23 pending approval by the ICAU supervisor and the incident was also being investigated by DSS. This monitor had not been notified by DSS that an investigation had been received, as required in the Baltimore County Child Abuse Agreement at Hickey. A subsequent check of the database revealed that the report had been submitted on 3/23 (ICAU Number 37476) and the report *inaccurately* indicated that the incident occurred on 3/18/2006.

Response:
This situation was reviewed and mitigating issues considered and appropriate actions were taken by DJS.

- Another example of an incident report being filled out incorrectly is ICAU Number 35236. The youth and staff names are entered in the wrong place. An e-mail was sent to the ICAU supervisor on 1/3/06 to make him aware of the discrepancy but the inaccurate information has not been corrected.

THE **MARYLAND YOUTH RESIDENCE CENTER (MYRC**) is a shelter care facility for up to thirty boys, ages 12 to 18 but its residential population has decreased due to the Choice Program that uses the facility to commit youth for 7 days only then works with them on Home Detention. 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. This monitor conducted four (4) unannounced visits at the facility according to the procedures established for the Juvenile Justice Monitoring Unit.

STAFFING

- Population:

The population at the facility has decreased due to the Choice Program (see Programming below). In January there were 18 youth in the facility and 1 was in the Choice Program. In February there were 24 youth in the facility and 2 were in the Choice Program.

- Staff:Youth Ratios:

Administrators advised they were moving towards having two staff on each unit. Each unit can accommodate up to 12 youth.

- Staff Behavior:

On 1/28, this monitor observed a direct care staff approach a youth from the rear and stick his finger in his ear while commenting, "You sure are quiet today." A subsequent conversation with the youth revealed that he was not upset by the staff's actions but it appeared to be disrespectful and unnecessary horseplay.

SAFETY AND SECURITY

- Aggressive Incidents:

The numbers of aggressive incidents appear to be on the decline as the population at the facility has declined. Youth on youth assaults declined from 13 last quarter to 5 this quarter. Use of force incidents remained the same from last quarter to this quarter at 2.

Unabated for 30 or More Days:

This concern has been cited repeatedly since the Quarterly Report submitted for the quarter of April through June of 2005.

- AWOLs and Facility Designation:

The Incident Report database AWOL incidents are still being designated as an "Escape from a Staff Secure Facility." During this past quarter, 21 incidents of youth running away from the facility were reported to the DJS Incident Report database. Of those, 19 were labeled "Escape" and 2 were labeled "AWOL." The facility is designated as a "shelter," youth are considered AWOLs and incidents should not be labeled as escapes.

EDUCATION

- MSDE is providing education at the facility. There are no significant concerns this quarter.

PROGRAMMING

Unabated for 30 or More Days:

This concern has been cited repeatedly since the Quarterly Report submitted during the quarter of January through March of 2005.

- Pending Placement Youth:

Youth are not supposed to be kept at the shelter for longer than 30 days, but as of 2/23/06 three youth had been housed at the facility for 30, 56 and 73 days respectively. The youth who had been there for 73 days was adjudicated on 12/12/05 but DJS had failed to find an appropriate placement for the youth. There were inconsistencies between staff, case management, medical and education as to why the youth had not been placed.

A meeting with DJS administration on 3/29 revealed that DJS is aggressively pursuing placements in community based and wrap-around programs; however, evaluations concerning education, somatic/mental health, substance abuse and family/social/delinquent history often expose high risk factors that might jeopardize the community. DJS is reportedly working with other State agencies (DSS, DHMH and MSDE) in an effort to address the problem with finding placements for these youth and develop a single point of entry into the system...

It should also be noted that the DJS administration is in the process of analyzing pending placement cases to determine some of the internal problems with supervision and case management to try and develop a more efficient process in maintaining a consistent link between the youth and their case managers. Administrators advised that there is more emphasis for the youth's DJS case manager to remain with the youth throughout their intake, detention and placement process.

Response:

The 'Department is seeking to develop a more coordinated case management system process for the youth in our care in need of more intensive programming and out of home placement. We are in the process of developing a Quality Assurance unit for community programming to ensure that all youth are managed in the most appropriate, efficient and effective manner.

- After-school and Weekend Programming:

Youth who were interviewed advised that they normally attend school from 9 to 3 then they have dinner, showers and movies until lights out at 9:30. Youth said they also take trips to churches and speakers come in to speak with them sometimes but they are generally bored due to the lack of activities.

- Choice:

The facility has been be partnering with Choice in Baltimore County and Baltimore City to provide additional programming for younger youth. The Choice program is a 7-day transitional program to help youth transition into placements. Twelve youth are supposed to be in the program at any one time but participation has been slight with an average of 2 youth going through the program each week. There was only one youth in the program on 1/28 and two were in the program on 2/23.

HEALTH/MEDICAL

- There were no significant concerns in the health or medical areas of the facility.

FACILITY MAINTENANCE

Unabated for 30 or More Days:

This concern has been cited repeatedly since the Quarterly Report submitted for the quarter of January through March of 2004.

- The repairs to the bathrooms are still pending DGS approval. The exterior of the facility was in acceptable condition.

CHILD ADVOCACY, INVESTIGFATIONS AND MONITORING
Unabated for 30 or More Days:
This concern has been cited repeatedly since July of 2005.

- Grievance Procedures:

This monitor has not received any monthly summary reports of grievances from DJS.

Response:
The Monitoring Unit is provided with or given access to every grievance generated by the department. We have continually noted that there is no grievance summary document completed by ICAU that can be submitted to the monitor. The monitor does receive copies of all incidents and grievances as required by the MOU.

THE **SYKESVILLE SHELTER CARE** facility is a private shelter care licensed by DJS on State property that can house and provide services for up to 10 females. This monitor conducted three (3) unannounced visits at the facility according to the procedures established for the Juvenile Justice Monitoring Unit. The facility continues to provide outstanding services to the females assigned to the program.

STAFFING:

- Population:

The population fluctuated between 8 and 10 during this monitor's visits.

- Staffing:

Staff to youth ratios were found to be acceptable throughout the reporting quarter

SAFETY AND SECURITY

- There were no significant concerns involving safety and security. There were 5 reported incidents of AWOLs last quarter and only 2 this quarter. There were no aggressive incidents reported.

EDUCATION:

- The education provided by this facility continues to be very focused and comprehensive to meet the needs of the youth.

PROGRAMMING:
The facility continues to provide outstanding programming services.

- On 2/22, this monitor observed the youth actively participating in a map skills class that was being conducted by a church volunteer.
- On 3/16, youth spent the day with staff at the art museum in Westminster and went to a band concert at a local high school.
- The youth still travel to the local YMCA for swimming and recreation several days each week.

HEALTH/MEDICAL:

- The facility had some concerns with not being reimbursed by DJS for prescribed medications for a youth that had to be paid for with the facility's own funds. The clinical staff are attempting to resolve this issue.

FACILITY MAINTENANCE:

- The interior and exterior of the facility were maintained properly; however, the driveway area has some large holes near the basketball playing area and is in need of repair.

ADVOCACY, INVESTIGATIONS AND MONITORING:

Unabated for 30 or More Days:

This concern has been cited repeatedly since the Quarterly Report submitted for the quarter of July through September of 2005.

- Grievance Summaries:

This monitor has not received any recent monthly grievance reports pursuant to the Standard Operating Procedure developed between this office and DJS.

Unabated for 30 or More Days:

This concern has been cited repeatedly since the Quarterly Report submitted for the quarter of July through September of 2005.

- Reporting and Investigations:

Although DJS is in the process of establishing a written agreement, there is still no written interagency agreement between the facility, DJS, DSS, MSP and the States Attorney's Office for handling child abuse and assault incidents.

THE **THOMAS O'FARRELL YOUTH CENTER (TOYC)** is an unlocked, staff-secure, privately managed residential program for male youth who are committed to the Maryland Department of Juvenile Services. The facility also maintains an off-grounds transitional living continuum (TLC), which is designed to provide a safe, secure environment for youth to support a successful transition from residential treatment back to the community. This monitor conducted four (4) unannounced visits at the facility according to the procedures established for the Juvenile Justice Monitoring Unit.

STAFFING:

- Staff:Youth Ratios:

Staff-to-youth ratios were found to be acceptable throughout the reporting quarter. On 3/16/06 at 9:30 PM, this monitor observed staff on duty and alert at the facility. There were 42 youth in bed and 5 staff providing coverage at the time.

SAFETY AND SECURITY

Unabated for 30 or More Days:

This concern has been cited repeatedly since the Quarterly Report submitted for the quarter of July through September of 2005.

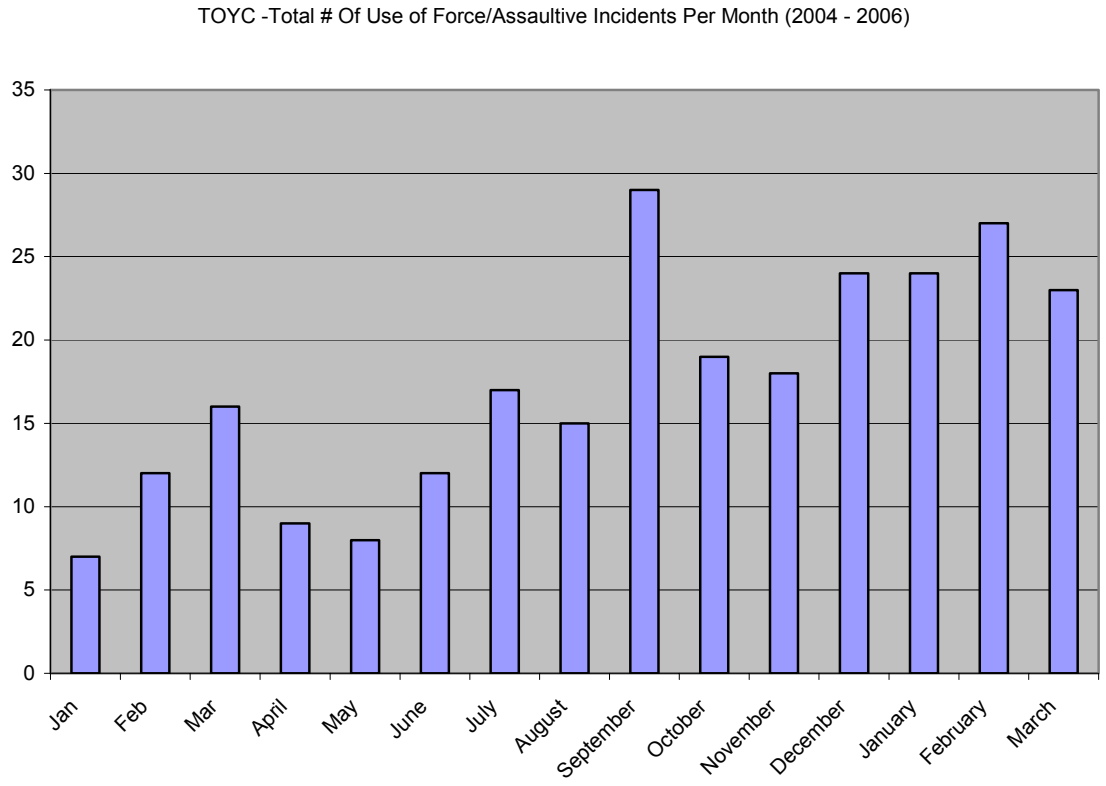
- Aggressive Incidents:

It appears that the trend for aggressiveness and violence has continued to climb at the facility. Incidents of youth on youth assaults increased from 21 incidents during last quarter to 37 incidents this quarter. The numbers of use of force incidents remained relatively constant at 38 reports last quarter and 36 reports this quarter.

The following information was obtained from the DJS Incident Report System database for 2005 - 2006:

	Y on Y Aslt/Riot	Y on S Aslt	CHAB	UOF	**TOTALS**	Avg.# 0f Assaultive Incidents Per Day
Jan	4	0	0	3	**7**	**0.2**
Feb	7	0	0	5	**12**	**0.4**
Mar	8	0	0	8	**16**	**0.5**
April	8	0	0	1	**9**	**0.3**
May	8	0	0	0	**8**	**0.3**
June	9	0	0	3	**12**	**0.4**
July	10	2	0	5	**17**	**0.6**
August	8	1	0	6	**15**	**0.5**
September	8	0	0	21	**29**	**1**
October	10	3	0	9	**19**	**0.6**
November	1	0	0	17	**18**	**0.6**
December	10	2	0	12	**24**	**0.8**
January	13	0	0	11	**24**	**0.8**
February	16	0	0	11	**27**	**1**
March	8	1	0	14	**23**	**0.7**
TOTALS	**128**	**9**	**0**	**126**	**260**	**0.58**

Key:
Y on Y Aslt = Youth on Youth Assault; Y on S Aslt = Youth on Staff Assault
CHAB = Child Abuse; UOF = Use of Force



It should also be noted:

- There were 5 youth on staff assault incidents last quarter and 1 incident this quarter.
- Reports of illegal contraband and illegal substance incidents dropped from 12 incidents during last quarter to 4 incidents during this quarter.

- Facility Intake Unaware of a Youth's Escape History:
  - On 3/11/06, a youth escaped from the facility by jumping from his bedroom window and running through the woods (ICAU Report Number 37186), while staff was using the restroom without being properly relieved by other staff. Although the youth had a history of escape prior to his acceptance into the facility, the facility administrator said he was unaware that the youth was an escape risk. The record of a previous escape was in the youth's ASSIST file. The facility administrator said they do have access to ASSIST information but they cannot refuse to accept the youth anyway. This monitor spoke with the DJS case manager and her supervisor about the information and they advised they thought the information had been shared with the facility but there would be a more concerted effort to communicate effectively for future placements.

EDUCATION:

- Library:

An MSDE audit revealed that the facility's library was not sufficiently stocked with updated reading and reference material but the facility has recently purchased new resource material for the library and is 90% completed.

- Special Education:

The facility continues to try and meet the educational needs of its special education population. On 1/31/06, there were 17 youth at the facility who required special education services and several more special education staff have been hired.

- GED Funding:

According to facility administrators, the State has reduced it's reimbursement for GED testing. The State did pay $100 per test but it currently only reimburses the facility $25.

PROGRAMMING:

- Cognitive Behavioral Training:

The administration at the facility are collaborating with McDaniel College staff and graduation students to establish an effective cognitive behavioral training program for the facility staff persons.

- Transitional Living Continuum:

On 2/22, there were seven youth at the TLC. There did not appear to be a diligent effort to have these youth involved in programming that would meet their needs for transitioning into the community. Only one youth was working at a local bagel shop. One youth had just reportedly graduated with his GED, four others were working towards their GEDs and one was going back to high school. All youth were orderly and busy preparing their dinner.

- "Community First" Training:

The facility continues to emphasize the importance of taking care of one's own community. On 1/31, approximately 10 youth were observed practicing walking in a straight line. They were very orderly and respectful throughout the observation.

HEALTH/MEDICAL:

There were no significant concerns in the areas of health and medical.

FACILITY MAINTENANCE:

- Facility:
  - The rear of the facility is still in need of some upkeep. Leaves and trash are gathered in corners and along the walls. The decking area behind the kitchen is warped and dangerous to walk on.

Unabated for 30 or More Days:

This concern has been cited repeatedly since the Quarterly Report submitted for the quarter of July through September of 2002.

- Transitional Living Continuum:
  - The house was in good order on the inside and the appearance on the outside was acceptable, except for the outbuilding that continues to require demolition or serious repair.

ADVOCACY, INVESTIGATIONS AND MONITORING:

Advocate Visits:

- Staff and youth advised they only saw the DJS Child Advocate about 1 time each month.

Unabated for 30 or More Days:

This concern has been cited repeatedly since the Quarterly Report submitted for the quarter of July through September of 2005.

- Grievance Summaries:

This monitor has not received any recent monthly grievance reports pursuant to the Standard Operating Procedure developed between this office and DJS.

Response:

The Monitoring Unit is provided with or given access to every grievance generated by the department. We have continually noted that there is no grievance summary document completed by ICAU that can be submitted to the monitor. The monitor does receive copies of all incidents and grievances as required by the MOU.

- Inaccurate Reporting:

Incident report number 35331 has the youth and staff names entered in the wrong locations.

Response:

The Data Base for the Department has been enhanced and has been designed to eliminate the challenges we had with incorrectly entered data.

Unabated for 30 or More Days:

This concern has been cited repeatedly since the Quarterly Report submitted for the quarter of April through June of 2005.

- Memorandum of Understanding:

There is still no written interagency agreement between the facility, DJS, DSS, MSP and the States Attorney's Office for handling child abuse and assault incidents.

Response:
We are in compliance with the law as it relates to Child Abuse Investigations and there is no requirement that we have a MOU. We will however begin meeting with the appropriate agencies to develop a MOU for this facility and area.

THE **ALLEGANY COUNTY GIRLS GROUP HOME (ACGGH)** is located in Cumberland Maryland on property that is owned by the Department of Juvenile Services. The program is operated by the Cumberland YMCA, and serves nine female residents. The program functions as a "healthy-home" model, and relies on community resources for education, counseling, and health services. ACGGH offers a valuable treatment program for females that can be accommodated in a community setting.

STAFFING:
ACGGH maintains a minimum of two staff on duty at all times, including overnight. A weekend "floater" staff person is also present to provide additional security and programming options. Director Cindy McGill often works so that she is present not only during the day but also during some evenings and on some weekends as well. Weekly staff meetings are held to provide training and to discuss concerns. Measures are reportedly being taken to ensure that staff are properly trained as per COMAR regulations.

SAFETY AND SECURITY:
Safety and security has been an issue due to the problem of some staff not having all of the required training. As mentioned, this concern is reportedly being addressed. Another area of concern has arisen during this period due to youth having access to caustic cleaning substances. Those cleaning supplies are now being stored in the garage. However, the inside door to the garage is not as secure as needed. The locks could be removed or compromised with minimum tools.

- Some staff lack the necessary training required by COMAR. This should be remedied as soon as possible. In the meantime a staff without training should only act as a shadow staff with a trained staff member.

Response:
Weekly training is provided for staff that became effective March 1, 2006. Staff training is a priority.

- Cleaning supplies and any and all potentially hazardous materials and substances should be secured to prevent youth from gaining access to the storage area.

Response:
It is the policy of the group home that all cleaning supplies and all potentially hazardous materials and substances are secured are double locked in the garage.

EDUCATION:
Most of the youth attend public schools in the area. Others work on preparing for the GED exam. At times some of the youth have attended Allegany College of Maryland. Diane Markwood, the Educational Coordinator for the Allegany County Girls Group Home, makes frequent visits to the schools to help support the girl's academic success. It is reported that overall, the residents are doing well in school, usually bringing home A's and B's.

PROGRAMMING:
Allegany County Girls Group Home utilizes a level system. Daily points are awarded for appropriate behavior in a number of areas. As the youth gain points they are eligible to advance to the next level of privilege and responsibility. Home passes can be earned by the residents to spend time with family members. It is possible for a youth to earn her way through the program in about nine months providing she doesn't experience major set-backs during her stay. Typically, youth do have some set-backs either at the program site, in the local community or on home visits. These problems are usually necessary aspects of treatment that must be addressed but, which, also extend the overall length of the program for that individual. Occasionally ACGGH has been referred and accepted youth that have demonstrated over time that their needs exceeded the program's capability. As a result some youth have had to be discharged unsuccessfully.

The girls at ACGGH receive formal individualized counseling sessions. Additionally, group sessions are held in the home when needed to resolve conflicts. Psychologist Dr. James Miller's visits the group home two days per week, Mondays and Thursdays, in order to allow sufficient time to go over the needs of each youth, and to provide training to the staff on pertinent issues such as group dynamics. The dynamics of the group at any given time is a key factor in the overall functioning of the program. The level of staff functioning is also critical to the effectiveness of the program. At times staff members have lacked the necessary skills to intervene effectively and facilitate problem resolution when conflicts arise within the group.

The schedule is full for the youth during the school year. On weekends, if the youth have earned the privilege, they may go to the mall with staff, or to movies, to the YMCA or to dances hosted by the Y. Many other assorted activities are held, including guest speakers, and special outings and events. Holidays are celebrated with decorations, food, and activities.

Health and Medical:
Health and medical needs are met by community resources, and reportedly are adequately meeting the needs of youth.

Facility and Maintenance:
Overall, the house is in good condition, and is well maintained by the cooperation of the Department and the YMCA. The door leading to the garage from the basement is not secure. Old files are kept in some unlocked file cabinets in the garage. The dressers used by the youth are in very poor condition. There is a lack of closet space in the upstairs dorm area. The lounge furniture in the den is badly worn. Additionally, the ceiling in the den is old and in need of replacement.

- The dressers should be replaced.

- Closets or a combination of closet and built in dresser should be provided in the upstairs dorm area.

- The lounge furniture in the den should be replaced.

- The ceiling in the den should be replaced.

● **Unabated for 30 Days or More:** The driveway leading to the facility should be repaired. This concern was first noted in the April-June Quarterly Report of 2003.

● Advisory board meetings should be scheduled regularly. An active advisory board could be helpful to the facility.

THE DEPARTMENT OF JUVENILE SERVICES YOUTH CENTERS provide commitment care services for a total of 156 male youth, in four separate facilities: Green Ridge, provides 40 beds, and serves Area III youth in three separate programs. Savage Mountain provides 36 beds, and serves non-Area III youth. Backbone Mountain, provides 40 beds, and serves non-Area III youth. Meadow Mountain, provides 40 beds, specializes in treatment of addictions, and serves non-Area III youth.

REGIONALIZATION:
Green Ridge Youth Center has three program components serving Area III youth exclusively. The programs include: Re-Direct, an intensive 30 day program, Reevaluation, a substance abuse program lasting a minimum of 120 days, and a Therapeutic Program lasting around 6 to 8 months on the average.

STAFFING:
A number of Youth Center direct care staff members have been temporarily detailed to the Noyes detention facility.

● **Unabated for 30 Days or More:** The staffing shortage was already affecting overall programming at the Youth Centers before the special assignments to Noyes began. The issue of staffing shortage was first noted in the October-December Quarterly Report of 2003. Staffing shortages threaten safety and security, especially with the Centers receiving more violent and challenging youth. These youth often require much more one on one time with staff. In addition, vacations, training, sickness, call outs, and medical leave also contribute to the shortage problem. Due to the lack of direct care staff, Case Managers and supervisory personnel must schedule themselves to be in direct care coverage, and this in turn makes it difficult for these staff members to complete their other duties.

Second shift and weekends are particularly difficult to cover. Though the Youth Centers are "staff secure" programs, sometimes on second shift and on weekends, there are only 4 direct care staff members in coverage for 36 to 40 youth. In the Meadow Mountain staffing report January 31st 2006, for example, it is reported that the day shift had only 4 direct care staff on 20 days out of the month. During weekdays this is not as alarming because administrative and teachers are present. On the weekends which represent 4 of the days, the situation is more critical. The evening shift was staffed with only 4 staff on 8 days out of the month. Two of these days were weekend days. This compromises safety and security and limits programming anytime, but is of even greater concern on weekends. At times direct care staff have been required, with only 4 staff on duty, to also get the evening meal out and served. It is impossible to provide adequate supervision at the same time. If a staff member needs a bathroom break, or if one or more incidents should occur the situation could easily become overwhelming.

● Clinic runs also affect staff coverage. Transportation staff is supposed to transport youth to the clinic. Due to transportation staff shortage and also the new transportation policy, direct care staff members have to leave coverage assignments in the Centers to

assist with clinic transportation. In a sample taken from Meadow Mountain Youth Center in January and early February direct care staff either had to make the clinic run or assist with the run on 8 separate days. This leaves the Center short handed.

● **Unabated for 30 Days or More:** Though Meadow Mountain is supposed to be a substance abuse treatment center and the Addiction Counselors are supposed to focus on their treatment groups, due to the lack of staff coverage, the counselors have to be placed in direct care. In addition to Addiction Counselors having to be in direct care coverage, the program is already in need of two more Counselors just to provide the necessary treatment services mandated. There is just one Counselor for each group, and each Counselor doubles as a Case Manager. Two Addiction Counselors are needed for each group to provide treatment meetings during evening hours and on weekends, and additionally, to cover all of the case management requirements plus the addictions administrative requirements. This concern was noted in the October-December Quarterly Report of 2005.

● **Unabated for 30 Days or More:** The intake office at the Youth Centers is staffed by only one person. Additional full-time help is greatly needed not only to cover for vacation, training, or sickness, but just to manage on a daily basis. On the average, nearly 100 referral packets are received each month at the Youth Centers to be reviewed. At any given time there are 75 to 85 packets in the process of being researched and reviewed for possible admission. The pressure to accept more challenging youth and youth with more violent offences makes the process much more difficult and time consuming. In addition to the review of referrals, the Youth Centers enroll around 45 youth each month, more than one a day. This process also is time consuming and too much for one person to handle alone. This concern was first noted in the October-December Quarterly Report of 2005.

SAFETY AND SECURITY:
The lack of adequate staffing noted above is a critical safety and security concern.

Unabated for 30 Days or More: The population has included more challenging and violent youth as noted. This concern was first raised in the October-December Quarterly Report of 2002, and raised consistently through the Quarterly Reports through June of 2004, then raised again in the July-September Quarterly Report of 2005, and subsequently in every Quarterly Report. The graph below may be only a partial representation as many charges are pled down to lesser convictions. Though 5 youth are shown to have 1st degree assault convictions in the February 21st census report, 19 youth are listed with 2nd degree assault convictions. Some of these youth are known to have been involved in very violent behaviors. In the same census report, 35 youth are listed only as having a Violation of Probation, with no indication of the prior convictions that initially necessitated probation. Many youth, possibly as many as a quarter of the Youth Center population, are members of various gangs. The presence of rival gang members, especially coupled with lack of staff, adds considerably to threaten safety and security.

	Feb. 05	March 05	May 05	July 05	Aug. 05	Sept. 05	Oct. 05	Dec.05	Feb. 06
Robbery	3	5	5	9	11	9	10	16	15
Burglary	8	9	10	12	12	12	12	12	10
1st degree Assault	1	1	2	2	2	2	3	3	5
Hand Gun Violation	0	0	0	0	0	0	2	2	3

- **Unabated for 30 Days or More:** Youth being admitted into the staff secure Youth Centers are screened, often extensively. Some youth that are turned down because of a concern that they may present a danger to others, or have needs beyond the Youth Centers ability to provide, are accepted nevertheless when a higher DJS authority insists that the youth be admitted. Incidents at the Youth Centers have increased considerably. This concern was first raised in the October-December Quarterly Report of 2005.

INCIDENTS:
Three youth escaped from the Backbone Mountain Youth Center in January 2006, and stole a van from the local area. Backbone Mountain in particular has seen a dramatic increase in incidents, particularly the need for use of force intervention. There has been a concern expressed about the number of incidents, which sometimes translates into a perceived subtle pressure not to report all incidents, especially if they seem to be minor. Generally, incidents are reported as required, which is to be commended.

	April/June 05	Y on Y	Y on S	U of F	Injury	Del/Crim Act	Total
Green Ridge		1			1		2
Savage Mt.				2	2		4
Meadow Mt.				1	3		4
Backbone Mt.		1		4			5
	Total	2		7	6		**15**
	July/Sept. 05	Y on Y	Y on S	U of F	Injury	Del/Crim Act	Total
Green Ridge		1		3	1	1	6
Savage Mt.		2		1	1		4
Meadow Mt.		3		5			8
Backbone Mt.		3		3	1		7
	Total	9		12	3	1	**25**
	Oct./Dec. 05	Y on Y	Y on S	U of F	Injury	Del/Crim Act	Total
Green Ridge		4		2	4	1	11
Savage Mt.		2		2	1		5
Meadow Mt.				3	3	1	7
Backbone Mt.		1	2	5	3	1 (Escape)	12
	Total	7	2	12	11	3	**35**
	Jan./March 06	Y on Y	Y on S	U of F	Injury	Del/Crim Act	Total
Green Ridge		7		2	1	2 (1-Escape)	12
Savage Mt.		3		1			4
Meadow Mt.		8		1	3		12
Backbone Mt.		8	2	19	3	1 Escape	33
	Total	26	2	23	7	3	**61**

Key: Y on Y (Youth on Youth Assault) Y on S (Youth on Staff Assault) U of F (Use of Force)
Del/Crim Act (Delinquent or Criminal Act) Injury (Accidental Injury)

Education:
The Youth Centers are accepting some youth that have been turned down by specialized schools. Youth in the categories necessitating 10-19 hours and 20 + hours are often in those categories because of behavior, but all categories display various learning disabilities or other learning challenges. The youth in the 10-19 and 20 + categories often require more intensive supervision and structure than other youth. The information in the graph below is taken from the Youth Centers Special Education Monthly Report.

Hours of Serv./Wk	0-4 Hours	5-9 Hours	10-19 Hours	20 + Hours
May 1-31, 2003	8	6	13	4
May 1-28, 2004	8	7	13	6
April 1-29,2005	10	5	9	7
May 1-31, 2005	11	4	12	10
June 1-24, 2005	9	3	15	11
July 1-29, 2005	8	2	14	12
Aug. 1-31, 2005	6	2	15	15
Dec. 1-30, 2005	7	5	12	25
Jan. 1-31, 2006	8	7	9	25
Feb. 1-28	6	7	9	23
Mar. 1-31	8	9	15	14

● **Unabated 30 Days or More:** It is unclear as to what set of regulations apply to the Youth Centers Educational Program. This issue was first noted in the October-December Quarterly Report of 2003. The Centers appear to function like a Public Alternative Education Program, but are different as well. MSDE has not promulgated regulation that applies directly to the Department of Juvenile Services Educational Programs. The confusion is problematic in that it is unclear what calendar schedule the Educators at the Centers should follow. The Youth Centers enroll youth throughout the year. Many, if not most of the youth are behind in their educational work, and in need of remediation, and/or special education services. Clearly more youth are being enrolled that require specialized services and increased hours of service. One of the most valued and important aspects of their treatment while in the Centers is education. In the spring of 2003 the school schedule was changed at the Youth Centers. This was done without reference to any regulatory authority or guiding standard, as again, it is unclear as to the applicable regulations. The result was that 52 days of instruction were lost to the youth. The schools are closed every Wednesday afternoon, though Wednesday is counted as a full day. Additionally the educators now take off a total of 4 weeks of "professional days" throughout the year in addition to holidays and vacation days. These professional days are typically coupled with holidays, and result in long periods when there is no schooling. This is particularly difficult for the youth near the Christmas holidays, as tensions are frequently heightened and the youth need as much supervision and productive activity as can be provided. DJS Director of Education, Dr. Sheri Meisel, has reportedly been in the process of developing Standard Operating Procedures for DJS Educational Programs. There are no DJS commitment care standards, but DJS Detention Standards do reference educational standards.

Most youth interviewed identify school as being of value to them during their placement at the Youth Centers. Both small group class and individualized instruction is provided.

In February each Center focused on Black History. A number of students participated in the writing competition.

The aquaculture program is back in full swing at Meadow Mountain Youth Center. In March Mr. Metz and Mrs. Beiler took several students on a field trip to a fish hatchery where DNR uses refined water from a coal mine to raise trout. The students then helped DNR stock the North Branch of the Potomac River.

PROGRAMMING:

Though staff try to provide good programming, often, as mentioned, basic supervision has to take priority due to the more challenged and challenging youth being admitted. Lack of staffing is the most crucial factor that affects programming capability. Staff members simply cannot devote the individualized time needed when alone in coverage. One or two youth often require most of the staff member's time and as a result the less demanding youth often do not receive the treatment attention needed.

Though Meadow Mountain is supposed to be a substance abuse treatment center, and the Addiction Counselors are supposed to focus on their treatment groups, due to the lack of staff coverage, the counselors are being placed in direct care. This is another factor that forces the program to take on more of a supervision function rather than be able to focus on treatment issues. The youth are not receiving the services to the extent to which the program was designed, and to which they are entitled.

● **Unabated for 30 Days or More:** A very important aspect of the Youth Center treatment program is recreation. Funding for recreation has been very limited since the revision in the contract with AT&T. This issue has been raised since first being noted in the Quarterly Report of January-March 2005.

Unabated 30 Days or More: The new transportation policy limits the Youth Center's capability of taking groups off grounds. This concern was first raised in the July-September Quarterly Report 2005. In spite of these limitations the staff members at the Youth Centers have managed to arrange some off campus activities. About 30 youth from Meadow Mountain were treated to a jazz workshop in Cumberland. A group from Savage Mountain went to Frostburg State University to use the climbing wall, and a number of groups have used the swimming pool at FSU. Creative, on campus tournaments were also organized at Savage Mountain Youth Center. Utilizing off campus resources is becoming increasingly difficult because of the staffing and transportation problems mentioned.

● **Unabated for 30 Days or More:** The Ropes/Reflections Program which is located on the Meadow Mountain campus is another very valuable treatment tool. The Program was staffed by two full-time personnel in the past, but one of the positions was moved to direct care. The remaining Ropes/Reflections staff member had frequently been called into direct care and quit his position early this year. As a result, services provided to the youth had been very limited and then curtailed entirely. When fully staffed, and not called into direct care, the Ropes/Reflections staff would have the capability of providing valuable experiential services to Youth Center youth, and also serve many other youth as an early intervention and prevention experience. Staff members from the other Youth Centers, who are trained and certified, have assisted with their groups in the Ropes program when they are available. The Ropes/Reflections position has been advertised and reportedly filled with another staff member that will do double duty in direct care.

However, without being fully staffed, coupled with the overall staffing shortage, the Ropes/ Reflections can offer only a small part of its programming capability. This concern was first noted in the July-September Quarterly Report of 2005.

The Youth Centers do encourage family involvement. Green Ridge Youth Center has begun implementing home visits for Area III youth placed in the 9 month Therapeutic Group program. When a youth nears the end of his treatment, and has earned a home visit by successfully completing treatment goals, he initially goes on a short home visit, and if successful, may go on a longer home visit. This programming has been positive overall. Youth who were interviewed expressed a lot of enthusiasm for the family visitation and perceived it as a valuable incentive to complete the program successfully.

The other Centers have not implemented home visits as of yet, but the youth do make calls, and families may visit the Center. The difficulty with youth making collect calls is that the expense is prohibitive for many families. Youth have suggested many times that calling cards be allowed so that the calls can be more affordable. The Youth Centers are reportedly considering alternatives that will help the youth maintain contact and provide incentives to progress in the treatment program.

HEALTH/MEDICAL:

The DJS Youth Centers contract with the Allegheny Health Department for health services. Nurses make weekly rounds to the Centers. Youth are seen as needed. Youth that need more urgent care are either seen at the Health Department or referred to the local emergency room. Each Center has a copy of the Allegheny County Health Department First Aid Manual, and medical supplies are ordered through the Health Department and picked up at the clinic.

FACILITY MAINTENANCE:

● **Unabated 30 Days or More:** DJS was reportedly permitted to purchase only 7 vans this year. Only one van is slated to come to the Youth Centers. The old 15 passenger vans that are in use need to be replaced as the National Safety Board has found all 15 passenger vans to be unsafe. Each Center used to have 4 vans, but has lost a number of vans to other DJS facilities by request of DJS Headquarters. Each Center is in need of 4 vans in order to accommodate the various programmatic needs, and in order to have emergency transportation if required. This concern was first noted in the July-September Quarterly Report of 2005.

Advocacy/Investigations/Monitoring:

The Child Advocate makes weekly rounds to each Center unless on vacation, in training or on sick leave. An Office of Professional Responsibility and Accountability Investigator is assigned to the Youth Centers and responds as needed.

STANDARDS:

● **Unabated for 30 Days or More:** Commitment Care Standards are not provided for DJS commitment care programs as of yet. This issue has been consistently raised sine first being noted in the April-June Quarterly Report of 2004. It was reported that standards were being developed and would be presented in March of 06. The Standards have not been developed as reported, nor has the Juvenile Justice Monitoring Unit been invited to participate in their development. Youth Centers currently operate under a procedural manual and Secretary Directives.

WILLIAM DONALD SCHAEFER HOUSE is owned and operated by the Department of Juvenile Services, accommodates 19 male youth, and provides a three-month substance abuse recovery program. The facility is located in a nice setting on Druid Park Lake Drive in Baltimore.

STAFFING:

● Though Schaefer House has three additional Resident Advisors, still, at times there is not enough staff to maintain a 1 to 6 staff/youth ratio.

Response:

Please be advised that there is no requirement for a community based program to have a staff to student ratio of 1-6. The 1 to 6 ratio is for detention programs.

● Schaefer House used to have a full-time maintenance/grounds person. This position is greatly needed at the facility especially as so many repairs and projects are left undone. At this reporting, maintenance personnel visits are very sporadic and not even made consistently on a weekly basis.

SAFETY AND SECURITY:

● While generally good safety and security is maintained, and most staff are diligent in their work, a few staff tend to sit at the desk rather than to be actively involved with the youth or moving around in providing supervision.

EDUCATION:

The education program is cited by youth as being of value. Educators are described as very helpful. The GED program has also been very successful with a high percentage of youth passing the exam.

PROGRAMMING:

● The program consists of individual and group counseling, education, and additional on and off grounds activities. Youth have complained however that they sit too much because of the lack of variety of activities.

● Youth also say that some days they do not receive an hour of large muscle exercise as required. Staff members confirm that a youth that is being sanctioned might not get recreation. The Schaefer House does have an arrangement with the YMCA, and several times a week youth are taken to the Y for activities and exercise. There is new exercise equipment in the basement recreation area, but it hasn't been put together. The new equipment has been awaiting assembly for many months.

During this reporting period youth have participated in six weeks of photography instruction two hours per week. The Maryland Institute and College of Art provided the instruction, and each youth was provided with a camera.

Youth have also earned the privilege of going on special outings, such as to local museums. The facility is also seeking to work with Borders and Barnes and Noble to donate books for a library at Schaefer House.

Schaefer House has implemented an "upper level" room for youth that demonstrate significant progress in their treatment. Youth assigned to this dorm room have a later bedtime, are able to enjoy television, and they have a radio in their room. This program enhancement is creative and should help youth motivate themselves to earn the privilege.

This monitor has observed two drug treatment groups being conducted. Generally, the youth appeared to participate well in the groups observed.

Family visitation is accommodated on Sunday afternoons from 1 to 4pm.

Unabated for 30 Days or More: Following completion of the program Schaefer House tracks youth at 30, 60, and 90 days. Approximately 70% to 75% of the youth maintain compliance with their treatment goals 30 days after being released. At 60 days after release, approximately 60% to 65% of the youth maintained compliance, and at 90 days approximately 45% to 55% maintained compliance. Although in general the program appears to be successful in helping youth achieve treatment goals, more intensive aftercare services are needed to help youth maintain the successes post release. To have 45% to 55% of the youth failing after 90 days is very unfortunate. This concern was first reported in the July-September Quarterly Report of 2005.

HEALTH AND MEDICAL:
DJS provides a nurse who is available on a daily basis for sick call requests. To see the nurse, youth fill out a "Sick Call Request Sheet" and put it in the Sick Call Box.

Facility Maintenance:
● **Unabated for 30 Days or More:** The Schaefer House is in poor condition. Exterior painting and window repair in particular is badly needed. The Department of Juvenile Services has turned over the new construction needed at Schaefer House to the Department of General Services. DGS hired an architect to develop a plan and a time line for construction. A plan for exterior work was submitted by the architect firm, but repair has not begun. The concern about the poor condition of the facility has been noted consistently in the Quarterly Reports since 2002.

● Window air conditioners are used. According to the architect this has contributed to the damage to the windows and to the exterior painted surfaces. Also, the windows cannot be opened, and the screens cannot be cleaned and have accumulated dirt and debris. Not being able to open the screens could be dangerous to youth if there was an emergency.

● Upon visitation the grounds also are observed to be cluttered with leaves, sticks and sometimes even trash, particularly in the front of the building.

● **Carpeting:** The carpeting is in poor condition throughout the facility.

● **Unabated for 30 Days or More: Phone System:** The phone system is in need of an upgrade. Getting through has been problematic at times. Reportedly a new system will be installed that will directly connect Schaefer House with DJS Headquarters. This concern was first noted in the October-December Quarterly Report of 2005.

● **Unabated for 30 Days or More: Basketball court:** There is no padding on the goal posts. This concern was first noted in the October-December Quarterly Report of 2005.

● **Unabated for 30 Days or More: Kitchen:** Though it was reported that the Department has contracted with a cleaning company to complete a power cleaning in October 2005, as of this monitor's inspection on 3/16/06, the kitchen was filthy, especially around the perimeter. These concerns have been noted since the January-March Quarterly Report of 2005.

The stoves are greasy and dirty.
Some of the kitchen cabinets doors have fallen off.
Ceiling vents are greasy and dirty.
The floor drain under the largest sink is covered in a greasy substance.
There is a leak under the small sink.
The kitchen floor tile is old and discolored.
The ice machine has not worked for over a year.

● **Unabated for 30 Days or More: Cafeteria:** The flooring in the cafeteria needs to be replaced. This was noted in the October-December Quarterly Report of 2005. A requisition has reportedly been submitted to the Department.

● **Unabated for 30 Days or More: Sunroom:** The Department reports that DGS has hired an architect to develop a plan and Time-line for construction. Caulking is missing around the windows. This allows outside air to come into the room. The ceiling vent covers are missing. These concerns were first noted in the Quarterly Report of January-March, 2005.

● **Unabated for 30 Days or More: Dayroom:** The flooring in the back dayroom is soft. This issue was first reported in the October-December Quarterly Report of 2005.

● **Bedrooms:** Twenty new dressers have been provided, and 20 new chests have been ordered. The new chests have not arrived. The old beds and chests are covered with graffiti, some of which is gang related. It was reported that they would be sanded, or painted, but this has not happened.

● **Unabated for 30 Days or More: 2nd floor bathroom and 3rd floor bathroom:** A plan for reconstruction has reportedly been approved. Construction has not begun. The concern about the bathrooms was first noted in the January-March Quarterly Report of 2005.

● **Laundry Room:** A new heavy-duty washer and heavy-duty dryer have been installed in the hallway behind the kitchen. The old laundry room is in need of cleaning.

● **Boiler Room:** It is reported that the heating system is not sufficient. A new expansion tank has been installed, and a new outside thermostat was also installed. Hopefully this will solve the problem next winter.

● **Unabated for 30 Days or More: Recreation Room:** In the recreation area the walls are flaking and need to be sealed and painted. The entire area should be thoroughly cleaned. This concern was first reported in the January-March Quarterly Report of 2005. The area should also be checked for lead paint.

Response:
The Maintenance issues will be addressed in the Corrective Action Plans.

ADVOCACY/INVESTIGATIONS/MONITORING:
● The Child Advocate is present in the facility on Wednesdays to address the concerns according to the protocol. The youth have been critical of the grievance process at times, stating that "nothing changes".

THE **ALFRED D. NOYES CHILDREN'S CENTER (NOYES)** is a State owned and operated detention facility located in Montgomery County. Noyes houses both male and female juveniles and is designed to accommodate a total of 58 youth.

In January the Administrator at Noyes was relieved and replaced by Rene Page, Center Supervisor at Meadow Mountain Youth Center. Ms. Page is in an acting capacity and will remain at Noyes until the end of April 2006. A new Administrator, Anthony Winn, has been hired and will begin his duties at Noyes on April 12th 2006. Mr. Winn has been an Assistant Administrator at a detention facility in New York State and has 15 years of combined experience in working in private and public facilities.

The Department of Juvenile Services has been making an effort to correct the deficiencies at Noyes. There are many very difficult challenges to overcome in order for the Department to be able to provide basic safety, security, and the services at Noyes that are required for the youth in their care.

STAFFING:
During this reporting period there has been a significant change in the staffing pattern on the units at the facility. This has come as a result of new staff being hired and with the help from the DJS Youth Centers in providing extra staff temporarily. Additionally, new salary incentives are being provided by DJS to attract and retain staff at Noyes.

In a sample taken of 22 days in January 2006 the units on first shift, from 7am to 3pm, were single staffed 48% of the time. On second shift, from 3pm to 11pm, the units were single staffed 66% of the time. In a sample of 16 days taken in March 2006 both shifts had units with single coverage only 23% of the time, and thus, had at least two staff on the unit 77% of the time. While many of the staff members are new and/or inexperienced, this is a beginning step in providing better coverage of the units. A number of new direct care staff have been hired specifically for Noyes and are in the process of receiving basic training in order to help provide coverage on the units. Recruiting and hiring of direct care staff will reportedly continue until the facility is fully staffed.

● **Unabated for 30 Days or More:** In addition to the need for experienced direct care personnel, Noyes is lacking many other staff. Two additional Residential Group Life Managers are needed. The staffing issues affecting Noyes have been reported consistently in the Quarterly Reports beginning with the January-March 2004 Report.

● **Unabated for 30 Days or More:** There is only one full-time Case Manager. A minimum of three full-time Case Managers are needed. This issue was first reported in the October-December 2005 Quarterly Report.

● A second recreational position had been filled, but the recruit quit. This position is needed to ensure that the recreational needs of youth are being met.

● **Unabated for 30 Days or More:** Two additional Addiction Counselors are needed. This concern was raised in the October-December 2005 Quarterly Report.

● **Unabated for 30 Days or More:** A Social Worker is needed to assist Dr. Mason with the delivery of mental health services to youth as required. This concern was reported in the October-December Report of 2005.

Response:
While the recruitment for this area has been difficult, the Department has developed incentives for hiring employees for this facility. A staffing plan has also been developed to improve the staffing at all facilities. We have placed special emphasis in this area as the new Region III re-organization plan is developed that is designed to pay more attention to the challenges at Noyes than in the past.

● **Unabated for 30 Days or More:** Lack of staff teamwork and lack of staff professionalism has been an area of concern at Noyes. Along with understaffing, at times, staff demeanor and attitude has been very problematic. This concern was first raised in the July-September 2005 Quarterly Report.

● **Unabated for 30 Days or More:** Some staff members have not been familiar with the policies and procedures, and there has been inconsistency in the facility in the application of policy from staff to staff. A comprehensive policy and procedural manual has not been developed as of yet for Noyes. Within this reporting period there have been several staff meetings to help address these concerns. It is reported that a policy and procedural manual will be developed. This concern was reported in the October-December 2005 Quarterly Report.

SAFETY AND SECURITY:
Safety and security has been seriously compromised as a result of staff shortages, staff inexperience, poor staff conduct, lack of programming, and overpopulation.

Though the rated capacity at Noyes is 58, the population count on March 22 was at 65. On March 30th the population reached 72 youth and with three more intakes, reached 75 on March 31st. Incidents at the facility have remained at high level and have risen in March as reflected below. Also the problem of youth being found with contraband has risen. This may be in part to more frequent and thorough searches being made by staff. In January two staff members were terminated as a result of allegations of child abuse. The subsequent investigation supported those allegations.

Month	Y on Y ASLT/Riot	Y on S ASLT	CHAB	UOF	TOTALS	Avg. # of Incidents Per Day
July 2005	9	1		6	16	0.51
August 2005	11	1	1	6	19	0.61
September 2005	18	1	2	4	25	0.83
Total	**38**	3	3	16	**60**	**0.65**
October 2005	29	1	1	2	33	1.06
November 2005	14			3	17	0.57
December 2005	13	1	Delinquent/ Criminal Acts by youth - 4	4	22	0.70
Total	**56**	2	5	9	**72**	**0.78**
			Child Abuse			
January 2006	12	2	2	2	18	0.58
February 2006	14	1	Possession of Contraband 1	5	21	0.75
March 28, 2006	15		4	4	23	0.82
Total	**41**	3		11	**62**	**0.72**

● **Unabated for 30 Days or More:** Noyes is lacking cameras, monitors, and recording equipment to record the behavior of youth and staff. This impacts the safety and security of youth and staff. Though hand held video cameras are available to use, this is impractical, and inadequate to ensure the necessary documentation. It is reported by those interviewed that staff rarely use the cameras. By the time the camera is brought to the scene it is often too late to record the incident. This concern was reported in the July-September 2005 Quarterly Report.

EDUCATION:

● **Unabated for 30 Days or More:** Concerns about education were reported in the October-December 2005 Quarterly Report. While there are many plans to improve the educational services for the youth at Noyes, during this reporting period, very little education appeared to be taking place. Lack of effective staffing and the resulting lack of safety and security have made quality educational instruction very difficult to accomplish. Lack of space to break the population into small classes also greatly hampers education. One observed class with the 6 female residents seemed to be productive in that most of the youth were engaged to some extent in the lesson. This monitor was on one of the male units with 19 youth two direct care staff, both new to the facility, a teacher and a teacher's aid when a class was supposed to be held. The situation was chaotic, and dangerous. Youth were acting out without intervention, and many displayed absolute disrespect for teachers and staff.

The youth on the units at Noyes have widely differing educational abilities, learning difficulties, and educational histories. At least one Latino youth, who has been detained for over 220 days, speaks very little English. For other youth English is a second language. The curriculum does not meet the various needs of the youth. Additionally,

the curriculum revolves on a 30 day schedule and does not hold the interest or meet the needs of the many youths that have stayed in the facility for months.

Additional teachers are being hired for Noyes, and a total of five should be on board by the time this report is submitted. The Noyes Educational Director is working closely with Montgomery County Public Schools. It is reported that the Noyes teachers will be invited to attend Montgomery County teacher training and development sessions. Also, the Montgomery County Public School system has offered to allow Noyes to use their curriculum guides. This cooperation between the facility and the county will hopefully result in credits being more readily accepted by receiving schools upon a youth's release from detention.

PROGRAMMING:

● **Unabated for 30 Days or More:** Lack of adequate programming continues to be a significant problem at Noyes. This issue was first cited in the July-September 2005 Quarterly Report. In order to begin to provide good programming, the staffing issue must be resolved. Without sufficient experienced trained staff members that can provide the necessary safety and security, good programming is not achievable.

There continues to be excessive "down time" where youth are kept on the units in the day room watching, television, playing cards or dominoes, sleeping on the couches, or acting out due to boredom, lack of structured activities, and lack of adequate supervision. The problem is made worse by the presence of youth that are members of different gangs. Some of the incidents are gang related. Movement of the units throughout the facility is also problematic as units have contact with one another where rival gang members flash gang signs and make threats. At times when units eat in the gym/cafeteria and are separated only by a vinyl closure that divides the gym into halves youth have broken through the divider and have engaged in fighting. This monitor checked log books on two occasions and found that known incidents were not recorded.

The three-level program that assigns points and gives some added privileges as youth gain points is inadequate. It has been reported that the multi-level system used at the Western Maryland Children's Center will be adopted. This could be a very positive step in providing more adequate programming.

● **Unabated for 30 Days or More:** Concern about the pending population at Noyes has been consistently reported since the October-December 2002 Quarterly Report. The number of youth and the length of time that they await placement while in detention at Noyes continues to be of significant concern. On March 22, 2006 the pending placement population at Noyes numbered 25 youth. Of the 25 youth in pending placement status 15 had **total** lengths of stay in detention that exceeded 30 days, 117, 116, 102, 69, 59, 57, 55, 45, 40, 37, 35, 35, and 34 days. Of the above, 11 youth had been in **pending placement** status for over 30 days, 59, 55, 55, 50, 39, 37, 35, 34, 32, and 31 days. These youth are entitled to individualized treatment services that are not being provided at Noyes.

HEALTH AND MEDICAL:

● Noyes has four contractual nurses while other facilities have nurses with PIN positions which include benefits. At times, because of understaffing at Noyes the nurses report that they have had to escort youth to and from the units to the nurses station, and this puts

themselves and therefore the youth as well, at risk. Also sometimes it has taken up to an hour for a youth to arrive at the nurse's station for an appointment with the doctor.

● The medical room is very limited in size at Noyes, and there is no clinic beds provided for youth that are sick or have conditions that are contagious.

● Youth complain that sometimes they are not seen by the nurse or doctor when they place a sick call.

● **Unabated for 30 Days or More:** The food at Noyes is reported by staff and youth to often be cold upon delivery. The meals are prepared at RICA and transported to Noyes from that facility. Minimum temperatures are required by the Health Department. This concern was reported in the October-December 2005 Quarterly Report.

● **Unabated for 30 Days or More:** Supplies such as soap, lotion, shampoo, washcloths have been in short supply. Reportedly it takes a long time for the procurement process to work, and there is no process for ordering ahead of time before supplies run short. This concern was reported in the October-December 2005 Quarterly Report. At times staff members have had to go to a local store to buy the needed items. Youth also complain that their sheets are not laundered as required.

FACILITY AND MAINTENANCE:

● On February 7, 2006 this monitor, along with the new Director of Juvenile Justice Monitoring Unit, visited the facility and discovered that the boiler was not working. Unit II and Unit IV were especially cold. The vents were blowing cold air directly over the youths' heads. Some youth had to spend a very cold night in un-heated sleeping rooms.

● **Unabated for 30 Days or More:** If the facility were to experience a fire that prevented unit III from moving through the gym or to the front of the building, a secure fire escape route would be needed to the rear of the building. This concern was reported in the October-December 2005 Quarterly Report.

● **Unabated for 30 Days or More:** The beds in the sleeping rooms are not suicide proof, as they provide potential tie off points that a youth could use in an attempted suicide. This concern was noted in the October-December 2005 Quarterly Report.

● **Unabated for 30 Days or More:** The gym walls underneath the basketball goals used to have padding but only one pad is still on the wall. The padding is needed to help prevent injury to youth playing basketball. This concern was raised in the October-December 2005 Quarterly Report.

ADVOCACY, INVESTIGATION, AND MONITORING:

● At times grievance forms have not been available for youth on the units. Youth express that it doesn't help to write a grievance as they feel it doesn't make a difference.

DJS Office of Responsibility and Accountability (OPRA) conducted a number of investigations at Noyes during this reporting period, and sustained findings against several staff members. As mentioned, two staff members were terminated as a result of OPRA investigation. Several others were reprimanded as a result of the findings.

THE WESTERN MARYLAND CHILDREN'S CENTER is a State owned and operated detention facility located in Washington County just outside of Hagerstown. WMCC is designed to accommodate a total of 24 youth in two 6 bed pods and one 12 bed pod. At present only males are housed at the facility.

The population at WMCC has averaged over 30 youth during this reporting period. This is an average of 6 over the rated capacity. Additional youth sleep in day rooms in plastic mattress containers called "boats". Having youths over the rated capacity has made it more difficult to provide services and to maintain safety and security. Even with having to deal with these challenges, however, the staff culture at WMCC has remained positive and proactive in maintaining constructive programming.

Many of the physical plant concerns have been addressed or are being addressed. The major outstanding concern is the presence of the vitreous china fixtures in the bathrooms. When broken, the substance shatters into dangerous sharp shards that present a serious hazard to youth and to staff.

STAFFING:

● **Unabated for 30 Days or More:** WMCC continues to face major staffing concerns. Staffing concerns have been consistently reported beginning in the Quarterly Report of October-December, 2004. Staff vacancies, forced overtime, staff fatigue, call outs, sickness/injury, losing staff to other DJS facilities, and the need for even more staff when the facility is overpopulated have all contributed to the staffing crisis. In addition to these factors, vacations and training impacts greatly on the availability of staff, and points to the need for greater staffing levels to accommodate the needs of youth.

● **Unabated for 30 Days or More:** On the 6 bed pods there is only single staffing. This presents a safety and security concern. This specific concern has been consistently reported since the Quarterly Report of October-December, 2004. When the population on the small units goes over 6 it was reported to this monitor that double staffing has been approved. This communication apparently was not received by the facility. Additionally, when questioned, facility spokespersons said that it would be impossible to bring in an additional staff as they simply are not available to draw from. Having only one staff on a locked unit with eight youth, especially when two youth cannot be placed into sleeping rooms, presents a potentially dangerous situation. Additionally, when there is an "all staff duress call" in which all staff are required to respond to an incident, it leaves two youth unattended in the day rooms on the 6 room pods.

Second shift is particularly vulnerable as there are no administrative staff members or teachers in the facility to help out as during the day. During second shift there is supposed to be a Resident Advisor Supervisor on duty along with a roving staff member. Two roving are actually needed, in addition to the Supervisor especially when the facility is overcrowded. There are many factors that require staff attention on second shift in addition to providing basic supervision. Family visitation, youth intakes, medical calls, special treatment needs, doing the laundry, and filling out reports as required following an incident are examples of situations that require additional staff. Even by itself, the intake of a new youth requires that two staff be present. When only one or even two people are available to accommodate all of these needs it can easily stretch staff to the limit. If several situations or incidents occurred simultaneously, it could become overwhelming.

● **Unabated for 30 Days or More:** Other positions also need to be filled. WMCC was supposed to have a second Case Manager to accommodate the population. This position has not been filled. This concern was reported in the October-December Quarterly Report of 2005. The only Case Manager at WMCC is preparing to go on maternity leave for up to a year.

The second Addictions Counselor position has not been filled. This concern was reported in the October-December 2005 Quarterly Report.

Also the second Social Worker position has not been filled. This concern was reported in the October-December 2005 Quarterly Report.

SAFETY AND SECURITY:
Safety and security is affected by staff shortage, staff fatigue and inexperienced new staff replacing seasoned staff that have transferred to other facilities.

● **Unabated for 30 Days or More:** Over population of WMCC has also affected safety and security. Additional youth are required to sleep in the day rooms, and as mentioned, there is no place to separate and secure the additional youth during a crisis. The concern about over population has been consistently reported since the July-September 2005 Quarterly Report.

Incidents at WMCC have been on the increase as the table below indicates.

Month/Yr	Y on Y	Y on S	D/C act	U of F	GP. Dist.	Total
1-04	2	1		2	1	6
2-04				7		7
3-04				6		6
4-04	1			4		5
5-04				9		9
6-04	2		1	7		10
7-04	1		1	4		6
8-04	1	1	1	7		10
9-04	2			4		6
10-04	2			4		6
11-04				5		5
12-04	2			3		5
Total	13	2	3	62	1	**81**

Month/Yr	Y on Y	Y on S	D/C act	U of F	GP. Dist.	Total
1-05	1			5		6
2-05				6		6
3-05	5	1		6		12
4-05	2			13		15
5-05	1			13		14
6-05				14		14
7-05	7		1	15		23
8-05	5	1		8		14
9-05	9			14		23
10-05	11	1		13		25
11-05	3			3		6

12-05	4			7		11
Total	48	3	1	117		**169**

Month/Yr	Y on Y	Y on S	D/C act	U of F	GP. Dist.	Total
1-06	6			6		12
2-06	7		1	6		14
3-06	3	1		7		11

Key: Y on Y (youth on youth assault) Y on S (youth on staff assault) D/C act (delinquent or criminal act) U of F (use of force) GP. Dist. (group disturbance)

● As indicated by the information above, the total number of incidents more than doubled from 2004 to 2005, and the youth on youth assaults more than tripled during the year. After February of 2005 the population at WMCC began to be forced over its rated capacity of 24. The population has continued to go over capacity, frequently numbering 30 -34, and at times, going as high as 36. Safety and security is threatened.

● **Unabated for 30 Days or More:** The presence of vitreous china toilets and sinks in the youths' sleeping rooms and bathrooms presents a danger to youth and staff. This issue was first raised during construction of the facility in 2003, and cited in the Quarterly Report of July-September 2003, and in every Quarterly Report since that time. The Department states that it has been seeking a suitable substitute. This Office has recommended that stainless steel fixtures be installed. The Department agreed in (**January of 2004**) to a remediation plan that included: to replace the vitreous fixtures with stainless steel in no less than two bedrooms immediately; replace the vitreous fixtures with stainless steel upon any breakage or damage; and retrofit the remaining vitreous china fixtures with stainless steel within a three year period. This agreement has not been acted upon by the Department.

EDUCATION:

● Overall, education has continued to be maintained as required at WMCC. When the population is over 31 youth, some of the classes are held on the pods in order to accommodate everyone. Teachers have commented that typically it is much more difficult to gain and maintain youth attention when teaching on the pods. Recently Black History Month was celebrated with youth doing artwork and participating in writing contests.

PROGRAMMING:

The programming at WMCC is guided by the BMS (Behavior Management System). The multi level system offers youth graduated rewards and consequences. Each level is designated by a color band which the youth wear on their wrists to identify the level they are currently on. Each day the youths' behavior, progress, set backs, accomplishments, challenges, frustrations and goals are evaluated. Each day every youth has the chance to advance to a higher level, or lose a level or levels as indicated by evidence of the above. WMCC has also implemented "pod of the week" if a pod is deserving of that distinction. Earning pod of the week is celebrated with special activities for that unit.

The leadership staff members at WMCC have developed a culture that values an attitude of respect for youth even if the youths' behavior or attitude is not positive. Most of the direct care staff members have been able to support this attitude in their work, and supervisors have worked with the few staff that has had difficulty in this area. Usually the

youth respond to the staff in kind. Routine and order is generally maintained, and this establishes a structure that is predictable and thus provides a sense of security.

● When the facility has been overpopulated it has been difficult, especially with low staffing, to maintain the level of structure, programming and services that are needed to meet the needs of the youth. WMCC was designed to function not only as a detention facility but also as an assessment center. This has been difficult to achieve as basic supervision must take priority. Again, with overpopulation and under staffing, basic supervision has, at times, been very challenging to maintain.

● **Unabated for 30 Days or More:** Competency Training and Life Skills classes have been very valuable aspects of added daily programming, but have had to be limited to weekends. This concern was first reported in the October-December 2005 Quarterly Report.

● **Unabated for 30 Days or More:** A Young Father's Program has been in the developing stage for over a year without being implemented. It was first recommended that a Young Father's Program be provided in the July-September 2004 Quarterly Report.

Response:
The Department is assessing the appropriateness of this particular program and we have made the decision that this program will not be implemented.

● **Unabated for 30 Days or More:** Youth in pending placement status sometimes wait for long periods of time at WMCC. This concern was first noted in the April-June 2005 Quarterly Report. Staff members at WMCC have worked in conjunction with DJS Area III Community Services to try to expedite youths' movement through detention and into placement as determined by the adjudication and disposition process. Nevertheless, some youths remain in detention at WMCC for extended lengths of time. On 2/29/06 WMCC had a population of 28. Of the 28 youth 6 youth had lengths of stay over 30 days; 36, 36, 49, 70, 79, and 99 days. Of the 6 youth 4 were pending a court hearing, and 2 were pending a placement.

● **Unabated for 30 Days or More:** It is the practice in ASSIST to begin counting a youth's time in a facility anew each time the youth goes to court and returns under a different status. Also, it is the practice to begin the accounting of time over in ASSIST when a youth is moved to another detention facility. These practices give an inaccurate accounting of how long youth have actually been continuously detained. This concern has been consistently noted since the October-December 2004 Quarterly Report.

HEALTH AND MEDICAL:
Health and medical services at WMCC are provided as needed. This monitor has not been made aware of major difficulties in this aspect of delivery of service to the youth. There seems to be very good cooperation and communication between the direct care staff and medical personnel.

FACILITY AND MAINTENANCE:

Important physical plant improvements have continued to take place during this reporting period. ADA rails have been upgraded to reduce the risk of providing a potential tie off point for an attempted suicide. About half of the sleeping rooms have been equipped with suicide resistant beds, and the remainder of the rooms will reportedly receive the beds in the near future. The desks and stools, that presented tie off points, have been removed.

Tinting of the control room has reportedly been approved in order to prevent visitors from identifying youth, and also to prevent youth from gaining detailed information about the set up of the control room. This will help protect youth confidentiality and also enhance safety and security.

The sleeping rooms on the East and West sides of the center are being equipped with tinted windows. Lighting and outside cameras also help protect youth confidentiality, and provide added safety and security.

● **Unabated for 30 Days or More:** The sprinklers in the youths' sleeping rooms continue to be problematic as youth have been able to tamper with the units, setting them off, flooding the room and partially flooding the pod. The Department has responded that the issue has been researched and that a suitable sprinkler replacement has not been found as of yet. This concern was first noted in the October-December 2003 Quarterly Report.

● **Unabated for 30 Days or More:** Another area of concern is the outside recreation area. This area has proven vulnerable to escape, and other potential escape routes from the recreation area have been identified. Additional fencing is needed to secure the area but has not been provided. This issue was first noted in the July-September 2004 Quarterly Report. As a result extra staff members are required to help provide supervision when youth are using the outside recreation area. With shortage of staff, this has resulted in youth not being able to have outdoor recreation as often as they could if the fencing were provided.

As mentioned under "Safety and Security", but is also a physical plant concern, is the use of vitreous china in the youths' sleeping rooms and bathrooms used by youth. As a result of the vulnerability to the toilets being broken by youth slamming the toilet seats, all of the toilet seats have been removed from toilets used by the youth.

ADVOCACY, INVESTIGATION, MONITORING:

● **Unabated for 30 Days or More:** Many of the Community Case Managers do maintain regular contact and visitation with youth at WMCC. Some Case Managers maintain little or no contact. Montgomery County Case Managers do not generally maintain contact as required. Special assignment youth that have been placed at WMCC especially from Baltimore City have received very little or even no contact from their Community Case Managers. This issue was noted in the July-September 2005 Quarterly Report.

● **Unabated for 30 Days or More:** Community Case Managers visits are not recorded in youths' ASSIST file. This concern was noted in the July-September 2005 Quarterly Report.

THE CHELTENHAM YOUTH FACILITY (CYF) is a State-owned and operated facility located in Cheltenham, Maryland. The maximum capacity is 110. 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 United States Department of Justice also monitors the facility through a Memorandum of Understanding.

- CYF housed approximately 90-130 male youth during this reporting period.

STAFFING:

- Cheltenham has twenty-six direct care vacancies. The staff members work overtime to provide supervision during staffing shortages.

- The facility has twelve case manager vacancies. DJS states that it plans to provide two case managers for each of the five cottages and intake area.

Response:
We are actively recruiting to fill the vacant positions.

- One day in January, seven dayshift staff members scheduled to work on dayshift failed to report for duty. Staff from DJS Headquarters and transportation responded to the facility to provide staff coverage. Some youth were late to school due to the staffing problem.

SAFETY/SECURITY:

- The facility had 76 fights during the January – March 2006 reporting period compared to 49 fights during the January – March 2005 reporting period. The following chart illustrates the serious incidents that occurred:

	Y on Y	Yon S	Contraband	Group Disturbance	Shelter AWOL's	Escape
Jan 2005	**22**	**2**				
Feb 2005	**12**	**1**	**1**	**1**		
Mar 2005	**15**					
Jan 2006	**29**					
Feb 2006	**24**	**2**	**1**		**2**	
Mar 2006	**23**	**1**	**4**			**1**

*Y on Y = Youth on Youth Physical Altercations; Y on S = Youth on Staff Assaults

- During this reporting period, fourteen youth were transported to Southern Maryland hospital for injuries sustained during the fights. The youth were transported for hand/finger/ankle sprains, lacerations requiring stitches, x-rays, fractured jaws, a broken tooth, and nose injuries.

- In February during a verbal confrontation between a staff member and a youth, the staff member allegedly pushed the youth into a television stand. The staff member was disciplined for the excessive use of force.

- During a February visit with her son, a parent notified staff members that a staff member might have assaulted her son within the past week. The staff member in question and a second staff member assigned to the housing unit failed to properly report document the altercation when it occurred. DJS disciplined the staff member for the excessive use of force. Maryland State Police arrested and charged the staff member for the assault.

- Another parent notified a CYF supervisory staff member that she received information about staff members permitting youth to fight one another. No documentation was made about the conversation. Within a few weeks, on March 14th, the parent's son was assaulted by another youth with a broom handle. A second youth assisted with the assault by punching the injured youth with a closed fist.

- On March 15th, a Rennie Cottage youth from Montgomery County was able to steal keys to a volunteer's personally owned vehicle (POV) and drove it through the facility's fence to escape. The volunteer left her car keys on a desk in the classroom and the youth picked them up before exiting the classroom. The youth was able to walk out of a classroom where two direct care staff members and a teacher were working. The youth then walked past a supervisor in the hallway, then out of the school building. The vehicle was parked in front of the school building so he ran to the vehicle and drove around grounds before driving through the fence. The following day, the vehicle was found in Montgomery County and the youth was arrested approximately 3 weeks later. Two staff members were disciplined after the incident. The damage to the fence was repaired within a few days of the escape. It should be noted that on during the March 1st unannounced visit, this monitor noted a February 16th Tour Office logbook entry notifying staff that this youth was to be considered a "high security risk" because he had escaped from the Alfred D. Noyes Children's Center in Rockville. The youth was admitted on February 17th, but the DJS investigation found no documentation in the Rennie Cottage logbook of the escape risk.

- Immediately following the escape, DJS headquarters no longer permitted personally own vehicles (POV) on-grounds. However, the day after the escape, this monitor observed a teacher drive his POV down to the school building and park it. He then exited with three other teachers. The staff member assigned to the gatehouse stated that the Assistant Superintendent authorized the POV to enter the facility.

- This monitor found incidents where the use of seclusion was not documented. In some cases, the incident itself was not documented and in others, placing youth in seclusion for more than eight hours was not documented. CYF administration has assured this monitor that they will monitor documentation of incidents more closely.

- On March 7th, a staff member reported to the Shift Commander that three youth were threatening to assault another youth. Approximately five hours later, the same staff member notified the Shift Commander that the youth was assaulted by one of the three aggressors.

EDUCATION:

- DJS has recently hired six teachers. The principal for the Charles H. Hickey School is assisting with supervising CYF's school until a permanent replacement is hired.

PROGRAMMING:

- This monitor has not received a copy of the evening programming schedule. This issue has been addressed in past monitoring reports and DJS has provided a recreation schedule but it failed to address substance abuse education and counseling, anger management, or life skills training.

HEALTH/MEDICAL:

- Recently CYF contracted with two mental health providers to provide services to the youth. The psychological evaluations are being completed in a timely manner, resulting in youth moving to their placements in a shorter period of time.

FACILITY MAINTENANCE:

- Because two vehicles were able to drive through the facility's fence along the back gate area, facility administration has requested that guardrails line the outside of that fence area. The guardrails could serve as a deterrent for vehicles or make it harder for a vehicle to be driven through.

- Although the facility was built many years ago, the physical plant is adequately maintained.

ADVOCACY/INVESTIGATIONS/MONITORING:

- This monitor has received no monthly summary grievance reports from DJS. If DJS is no longer preparing these reports, the JJMU requests copies of the monthly grievance summary reports from November 2003 thru January 2006. Since the Standard Operating Procedure for this Office and DJS became effective in November 2003, DJS has failed to provide the copies.

- Many youth in the facility stated that they understand the grievance procedure.

THE J. DEWEESE CARTER CHILDREN'S CENTER is a detention facility with a design capacity of fifteen male youth. In February, the Department of Juvenile Services (DJS) stated that the capacity for this facility is now twenty-seven youth. The facility operates under DJS Standards of Detention and other DJS policies and procedures. This monitor conducted announced and unannounced visits to the facility during this reporting period.

STAFFING:

Unabated for 30 or More Days: Carter currently has many staff vacancies; including six Resident Advisor positions, one Teacher's Assistant, one Nurse, and one Social Worker position. The staff works many hours of overtime and management level staff must work in coverage on the unit. The Kent County Administrator offered to allow DJS to use the Kent County Public Works Building as a testing site for potential candidates. This issue was first cited in the JJMU's October – December 2004 Quarterly Report.

SAFETY/SECURITY:

- The following chart illustrates the number of incidents that occurred during the October – December 2005 reporting period and the current reporting period.

	Youth on Youth Use of Force	Assaults	Group Disturbances
October 2005	2	2	1
November 2005	0	5	0
December 2005	1	1	0
January 2006	2	0	0
February 2006	2	4	0
March 2006	2	4	1

- The group disturbance on February 15th was witnessed by this monitor. It involved eighteen youth fighting amongst one another. Officers from the Chestertown Police Department and MSP responded to the facility but did not have to use force on the youth.

- In March, staff found a substance suspected to be marijuana wrapped in a skittles wrapper in a bedroom. Visitation takes place in the dayroom of the housing area for youth and their parents. Because visitors are not searched, contraband can be introduced to the facility.

EDUCATION:

- The education staff reported they have become frustrated with the increased population and staffing shortage because the youth are not as attentive. When the population increases over the design capacity of fifteen, the teaching areas become crowded. The classes are now held in the dayroom and small dining room of the facility. DJS has stated that plans are being considered to provide two modular units for classroom space. One unit would be considered the special education classroom and the other for a general education classroom.

- **Unabated for 30 or More Days:** Since 2004, the facility has had one vacant teacher's aide position. The teacher's aide provides one-to-one education to

youth in need of tutoring. The teacher's aide also teaches class in the teacher's absence.

- The computer lab in the facility provides adequate space for computer instruction. The youth have created a power point presentation for the facility's Black History Month program. In February, the youth wrote poems that they presented to the facility staff and youth during Poetry Night.

PROGRAMMING:

- **Unabated for 30 or More Days:** The facility does not have a gymnasium, the youth have never had a structured recreation program.

- **Unabated for 30 or More Days:** The facility does not have a gymnasium, a recreation coordinator has never been hired.

HEALTH/MEDICAL:

- The facility has a vacant social worker position. The facility does have a mental health worker through a contract with an outside agency. The DJS social worker could provide additional individual and group counseling. The social worker could also provide suicide prevention training for staff and other training related to mental health issues.

- **Unabated for 30 or More Days:** The facility has one vacant evening shift nurse position since this monitor was assigned to the facility in March 2001. Currently one full time nurse provides medical services to the youth during the dayshift and two contractual nurses cover the weekend shifts. Staff members stated the facility needs an evening shift nurse to provide medical services to the youth.

FACILITY MAINTENANCE:

- **Unabated for 30 or More Days:** The facility has never had a gymnasium. During inclement weather, the youth are not permitted outside and are not given strenuous physical exercise.

- **Unabated for 30 or More Days:** The facility's beds need to be replaced with a more suicide resistant model similar to the one installed in the Lower Eastern Shore Children's Center in April 2005. This issue has been cited since April, 2005.

ADVOCACY/INVESTIGATIONS/MONITORING:

- **Unabated for 30 or More Days:** This monitor has not received a copy of the monthly grievance summary report as required by the DJS/OIM Standard Operating Procedure. If DJS is no longer preparing these reports, the JJMU requests copies of the monthly grievance summary reports from November 2003 thru January 2006. Since the Standard Operating Procedure for this Office and DJS became effective in November 2003, DJS has failed to provide the copies.

Response:

The Monitoring Unit is provided with or given access to every grievance generated by the department. We have continually noted that there is no grievance summary document completed by ICAU that can be submitted to the monitor. The monitor does receive copies of all incidents and grievances as required by the MOU.

THE LOWER EASTERN SHORE CHILDREN'S CENTER (LESCC) is a State-owned and operated facility located in Salisbury, Maryland that 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 a twenty-four bed detention center 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.

STAFFING:

- **Unabated for 30 or More Days:** The facility continues to provide single staffing coverage on the two six-bed pods and double coverage on the twelve-bed pod. Many times, the Shift Commander is required to work in coverage due to inadequate staffing. This issue has been cited in the JJMU's Quarterly Reports since the facility opened in November 2003.

- The facility has eleven vacant direct care positions. The facility has had vacancies since it's opening in November 2003.

- In March, this monitor issued a Special Timely Report citing overcrowded conditions and a staffing shortage. During a March 4th unannounced monitoring visit, the JJMU found two staff members supervising the three housing units. The third staff member on duty was assigned to the Control Center due to a wrist injury suffered during a restraint of a youth.

SAFETY/SECURITY:

- The following chart illustrates the serious incidents that occurred in the facility during this reporting period:

	Y on Y	U of F	Y on S	Contraband	Property Damage
January	**8**	**3**	**2**	**1**	**2**
February	**4**	**0**	**0**	**0**	**2**
March	**4**	**2**	**4**	**1**	**0**

Y on Y = Youth on Youth Physical Altercations (fights)
U of F = Use of Force
Y on S = Youth on Staff Assaults
Contraband = Unauthorized Items
Property Damage = Damage to the facility by youth.

- In January, a diabetic youth stabbed a nurse in the stomach with a used syringe and another youth threatened to stab a staff member with a pencil.

- During this reporting period, staff found a toothbrush altered into a weapon (shank) and 2 other homemade weapons made from a notebook binder.

- On two separate occasions, a youth was able to break off the metal pipe connected to the toilet. During the first incident, the youth used the broken pipe to break the glass out of the room door during his seclusion period. During the second incident, the toilet water continued to run onto the dayroom carpet until the water was turned off. DJS has not made a decision as to replacing the porcelain toilets and sinks with a stainless steel model.

- In February, police failed to locate contraband on youth prior to taking transferring him to the custody of LESCC. After the Officer exited the facility, staff searched the youth and found eight pieces of individually wrapped suspected crack cocaine. The police returned to the facility to retrieve the substance.

- In March, during an incident in the visitation room, a female youth was able to get out of her room and attempted to release the locks on the other youth's door. The staff member failed to ensure that all youth were properly secured in their rooms. This issue was also cited in the October/November/December 2005 JJMU Reports for similar incidents.

- In March, the facility experienced three separate youth on staff assaults in one day. The first incident occurred when a youth choked a staff member sitting in a chair and they both fell to the floor during the struggle. Multiple staff members responded to remove the youth off of the staff member. The second incident occurred when a youth in seclusion struck a staff member in the face and threatened to repeat the action. The third incident occurred when a youth struck a staff member in the mouth with his fist.

- As cited in previous monitoring reports, the facility continues to lack proper documentation of incidents and seclusion.

EDUCATION:

- This monitor reported in November 2005 that the youth were not receiving a minimum of five hours per day of instructional time. This Office continues to monitor to ensure that the youth receive the required level of educational programming.

PROGRAMMING:

- The facility now has a case manager.

- **Unabated 30 or More Days:** The facility continues to operate without a Recreation Coordinator. This issue has been cited since the facility opened in November 2003. The position was filled for a brief period but the staff member resigned.

HEALTH/MEDICAL:

- The facility now has a mental health worker.

FACILITY MAINTENANCE:

- On three occasions, youth tampered with the fire sprinklers causing them to activate. Once activated, the dayroom carpet must be professionally cleaned to remove the excess water.

- **Unabated for 30 or More Days:** Youth have damaged the porcelain toilets and sinks in attempt to use the broken pieces as weapons. They have kicked the hard plastic lavatory shields off to access the plumbing. Because the fire sprinkler heads are not vandal resistant, the youth have tamper with them causing the dayrooms to be flooded. This issue has been cited in the JJMU's October – December 2004 Quarterly Report.

ADVOCACY/INVESTIGATIONS/MONITORING:

- **Unabated for 30 or More Days:** This monitor has received no monthly summary grievance reports from DJS. If DJS is no longer preparing these reports, the JJMU requests copies of the monthly grievance summary reports from November 2003 thru January 2006. Since the Standard Operating Procedure for this Office and DJS became effective in November 2003, DJS has failed to provide the copies.

Response:
The Monitoring Unit is provided with or given access to every grievance generated by the department. We have continually noted that there is no grievance summary document completed by ICAU that can be submitted to the monitor. The monitor does receive copies of all incidents and grievances as required by the MOU.

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.

STAFFING:

- Guide continues to have a dedicated staff and has no vacancies.

PROGRAMMING:

- The facility's computer still has not been equipped with DJS' ASSIST database as stated on the Office of the Independent Juvenile Justice Monitor's July-September 2005 Corrective Action Plan.

- The youth attend many weekly activities in the community.

EDUCATION:

- The education program continues to meet the needs of the youth.

FACILITY MAINTENANCE:

- **Unabated for 30 or More Days:** The facility needs extensive flooring repairs. The flooring in the main hallway is warped. The tile in the kitchen and dining room area is worn and needs to be repaired. This issue has been cited since January - March, 2004.

- **Unabated for 30 or More Days:** Mr. Bell also stated that the pipes require insulation to be protected from the cold winter weather. This issue has been cited since the JJMU's October – December 2005 Quarterly Report.

- **Unabated for 30 or More Days:** The basement/classroom has flooded on several occasions due to poor drainage during heavy rainfalls. A plumber recommended that the outside sewer should be cleaned at the main holding/distribution point. This issue has been cited since the JJMU's October – December 2005 Quarterly Report.

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 and operated by 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**.**

STAFFING:

- Mt. Clare House continues to have a seasoned and dedicated staff.

SAFETY/SECURITY:

- The facility had one youth AWOL in January and two youth AWOL in March. This is a non-secure community program.

EDUCATION:

- The youth attend the local public schools as required.

PROGRAMMING:

- The facility provides outstanding programming services to the youth.

THE YOUNG WOMEN'S FACILITY OF MARYLAND AT WAXTER is a State owned and operated detention/residential treatment facility that houses females under the age of 18. The single bed capacity is 68. The facility is comprised of one detention unit, one pending placement unit, and one secure committed program. Waxter is operated under the Department of Juvenile Services (DJS) Standards of Detention and other DJS policies and procedures.

STAFFING:

- Waxter is understaffed and some staff members were transferred from other DJS facilities to assist with supervising the youth.

SAFETY/SECURITY:

- The following chart illustrates the serious incidents that occurred during this reporting period.

	Y on Y-P	U of F	Y on S	SA	Y on Y-S	C	GD
January	**6**	**10**	**2**	**1**	**0**	**0**	**0**
February	**8**	**5**	**3**	**1**	**1**	**1**	**1**
March	**5**	**8**	**0**	**1**	**0**	**0**	**0**

Y on Y-P = Youth on Youth Physical Altercations (fights)
U of F = Use of Force
Y on S = Youth on Staff Assaults
SA = Suicide Attempts
Y on Y-S = Youth on Youth Sexual Assault
C = Contraband
GD = Group Disturbance

- In January, a youth was taken to Laurel Regional Hospital for a self-inflicted injury to her arm in a suicide attempt. In February, a youth already on one-to-one suicide observation was able to place a piece of glass in her mouth to cut her tongue. She also used a piece of metal from a pencil to cut her arm. In March, a youth swallowed a piece of glass from a fluorescent bulb.

- This monitor issued a Special Timely Report in March relating to a February 1st child abuse allegation. Ms. Perez and this monitor witnessed the incident and made all required notifications. The Special Timely Report cited issues relating to the alleged assault, staff member's responses, and the DJS investigation.

- In February, three youth caused a group disturbance by locking themselves in the laundry room until staff members were able to force the door open and remove the youth.

- In February, a staff member found a pill belonging to a youth in the Tour Office bathroom.

- During a February Department of Social Services (DSS) Multi-Disciplinary Review Meeting, this Office and a DJS Investigator learned about a youth on youth sexual assault allegation that occurred in November 2005. The incident was reported to DSS as child neglect because the allegation involved three female youth holding another female youth down during the sexual assault without intervention from staff members. Facility staff members reported the incident to DJS Investigators but an investigation did not occur. DSS and MSP closed their investigations citing neglect did not occur.

EDUCATION:

- The education trailers area has been where the many attempted escapes occur.

- Waxter youth receive the required five hours of instruction.

PROGRAMMING:

- The facility has been enhancing the programming schedule by adding a Book Club and allowing more volunteer organizations to provide services to the youth. The recreation program continues to need improvement.

- **Unabated for 30 or More Days:** The all female population in Waxter has not been afforded recreational resources as the male population in the male facilities. Some male facilities have a weight room, basketball tournaments, etc. Resources have not been made available for the females to have more gender specific recreation such as treadmills or aerobics classes, etc. This issue has been cited since October - December, 2005.

FACILITY MAINTENANCE:

- Administration reports that five showers and four toilets will be added to the detention unit's bathroom sometime this year.

- **Unabated for 30 or More Days:** The facility does not have a metal detector at the door. Staff stated that a security wand is available to detect possible contraband being brought into the facility. However, this monitor has never observed the device being used on people entering the facility. Visits occur within the secure area of the facility, visitors should be searched as required. This issue has been cited since the JJMU's October – December 2005 Quarterly Report.

ADVOCACY/INVESTIGATIONS/MONITORING:

- **Unabated for 30 or More Days:** This monitor has received no monthly summary grievance reports from DJS. If DJS is no longer preparing these reports, the JJMU requests copies of the monthly grievance summary reports from November 2003 thru January 2006. Since the Standard Operating Procedure for this Office and DJS became effective in November 2003, DJS has failed to provide the copies.

Response:

The Monitoring Unit is provided with or given access to every grievance generated by the department. We have continually noted that there is no grievance summary document completed by ICAU that can be submitted to the monitor. The monitor does receive copies of all incidents and grievances as required by the MOU.