

ANNUAL REPORT

JULY 1, 2004 – JUNE 30, 2005

THE OFFICE OF THE INDEPENDENT JUVENILE JUSTICE MONITOR



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INTRODUCTION

In accordance with the statutory responsibility delineated for the Office of the Independent Juvenile Justice Monitor, we respectfully submit this annual report, the fourth since the codification of the Office of the Independent Juvenile Justice Monitor in October 2002.

Over the past 4 years, this office has sought to be an instrument of change in the services and safety provided to the youth, staff and communities of this State. To that end, the Office of the Independent Juvenile Justice Monitor (OIJJM) maintains its commitment to working with the Department of Juvenile Services, and all stakeholders, in reporting on conditions impacting the services and safety to youth, staff and Maryland communities, and to developing corrective action plans.

This past year brought some uncertainty as to whether the Office of the Independent Juvenile Justice Monitor would be continued, and if it did continue, where it would be located. During the 05 Legislative Session, the Governor's Office for Children Youth and Families, Article 49D, under which the OIJJM was housed, was allowed to sunset as of June 30th 2005. On June 9th, 2005, Governor Robert L. Ehrlich, Jr. signed Executive Order 01.01.2005.35 re-establishing the Office of the Independent Juvenile Justice Monitor to be located in the newly created Governor's Office for Children.

As reflected in the reports generated by the OIJJM during the past year, the long standing issues confronting Maryland's juvenile justice system are numerous and serious, (see Outstanding Issues and Recommendations, pp. 15 of this report). Of major concern is the lack of adequate staffing, particularly in the detention facilities. Detention facilities continue to experience a high incidence of serious issues, including life, health, and safety concerns.

The lack of staffing impacts the ability, particularly of detention facilities, to provide adequate programming, and youth do not have a reasonable expectation of safety. Although the Department's Office for Professional Development and Training has increased efforts to train staff, some staff persons continue to provide very poor role modeling for the youth. In several instances, staff have been administratively and criminally charged for abusing youth. Seclusion has been improperly used for punishment purposes rather than the removal of youth who are an imminent danger to themselves or others. Also, the long length of stay for youth in pre-adjudication status, and in pending placement status in detention facilities has continued to be a significant unresolved issue.

The Baltimore City Juvenile Justice Center, Lower Eastern Shore Children's Center, and Western Maryland Children's Center, still have significant physical plant deficiencies that pose life, health, and safety concerns for both youth and staff.

There are still concerns regarding the implementation of effective interagency agreements to respond to the problems of child abuse and assaults within the facilities.

The Department has undergone several changes in its top level administration, and has openly acknowledged the existence of many of these issues. The child advocacy community also continues to play a vital role, regarding the issue of addressing the concerns noted above. The Office of the Independent Juvenile Justice Monitor looks forward to continuing in the work of assisting in the transformation of Maryland's juvenile justice system.

MISSION STATEMENT

To promote the positive transformation of the juvenile justice system to meet the needs of Maryland's youth, families, and communities.

This mission is accomplished by:

- Collaborating with all who are involved with the juvenile justice system;
- Collecting and evaluating all information;
- Reporting findings and recommendations; and,
- Monitoring actions taken.

HISTORY OF THE OFFICE OF THE INDEPENDENT JUVENILE JUSTICE MONITOR

During the winter of 1999, the former Maryland Department of Juvenile Justice received national media coverage concerning the treatment of youth in their boot camp facilities. A thorough task force investigation of the Department was ordered. One of the outstanding findings of this task force was that there was no oversight of the Department.

Recognizing the need for external review of the Department's residential facilities, the establishment of an Independent Juvenile Justice Monitor was proposed within the Subcabinet for Children, Youth, and Families. As a result, in February of 2000, the Department of Juvenile Justice and the Subcabinet for Children, Youth, and Families signed a Memorandum of Agreement (MOA) establishing the Office of the Independent Juvenile Justice Monitor within the Governor's Office for Children, Youth, and Families.

The responsibilities of the Independent Monitor, per the MOA, included reviewing and evaluating the child advocacy-grievance process in the Department of Juvenile Justice; the operation of the Department's Inspector General; the treatment of and services to youth; and the physical plant conditions in facilities.

In September of 2000, the Office of the Independent Juvenile Justice Monitor became operational with the hiring of two monitors. However, it became apparent that the Office of the Independent Monitor required additional staffing in order to adequately maintain a level of review consistent with its assigned responsibilities. In late March 2001, three additional monitors were hired through a grant from the Governor's Office of Crime Control and Prevention.

Legislation to codify the Office of the Independent Juvenile Justice Monitor went into law on April 25, 2002 with an effective date of October 1, 2002. As a result of HB 971, funding for the Office was derived from general funds and the statutory duties of the Office were identified to include the evaluation at each facility of:

- The child advocacy grievance process;
- The Department's monitoring process;
- The treatment of and services to youth;
- The physical conditions of the facility; and,
- The adequacy of staffing.

In order to carry out these functions, HB 971 provided that the Office shall:

- Review all reports of disciplinary actions, grievances, and dispositions and alterations in the status or placements that result in more security, additional obligations, or less personal freedom.
- Receive copies of the grievances submitted to the Department.
- Perform unannounced site visits and on-site inspections.
- Receive and review all incident reports submitted to the Department from facilities.
- Receive reports of the findings of child protective services investigations of allegations within facilities.
- Be available to attend meetings of the State Advisory Board and facility advisory boards.

Further, HB 971 provided that the Office may:

- Review relevant laws, policies, procedures, and juvenile justice records, including records relating to individual youth.
- On request, conduct interviews with staff, youth, and others.
- Review investigative reports produced by the Department relating to youth in facilities.

- Participate, within the context of the local department of social services' multidisciplinary team process, in a child protective services investigation concerning any allegation of abuse or neglect within any assigned facility.

In 2005 the statute authorizing the Governor's Office for Children, Youth and Families and the OIJJM was allowed to sunset. The General Assembly passed House Bill 1342 — Juvenile Justice Monitoring — Transfer to Office of the Attorney General to transfer all duties of the Office of the Independent Juvenile Justice Monitor from Office of Children, Youths, and Families to the Office of the Attorney General.

The legislation was subsequently vetoed by the Governor and the office was re-established in an Executive Order, which explained,

“The Attorney General would have been placed in the position of having employees of one unit within the office testifying against a Department represented by another employee within the office, thereby presenting conflicts which could jeopardize the integrity of the State's effort to ensure that juvenile facilities are operated in compliance with federal and State law.”

All elements of HB971 were re-established in the Executive Order.

STAFF

Ralph Thomas, Executive Director, directed and coordinated the activities of the office throughout the 2005 fiscal year. Mr. Thomas resigned from his position as Executive Director effective July 1, 2005.

Earl El-Amin, Deputy Director, assisted in the coordination of activities in the office. He resigned effective January 1, 2005 and his position was not filled.

Philip “Jeff” Merson, Juvenile Justice Monitor, monitors facilities in Central Maryland. He is responsible for the Charles H. Hickey School, the Baltimore City Juvenile Justice Center, the Thomas O'Farrell Youth Center, the Sykesville Shelter Home for females, and the Maryland Youth Residence Center. Mr. Merson served 26 years with the Maryland State Police and retired 1999. He was instrumental in establishing the Child Abuse Sexual Assault Unit in Carroll County, and he spent the last 6 years of his career with the FBI on a Violent Crime Task Force in Baltimore City. Upon retirement, Mr. Merson became the Admissions Coordinator for Bowling Brook Preparatory School, a highly touted private residential treatment facility for aggressive adjudicated young men. Mr. Merson then became an investigator with the Department of Juvenile Justice and served as the Assistant Director of Investigations from 2000 through 2001 before joining

the Office of the Independent Juvenile Justice Monitor. Mr. Merson holds a Master's degree in Education from Loyola College.

Kim Bones, Juvenile Justice Monitor, works with facilities in Eastern Maryland. She monitors the Thomas Waxter Children's Center, Cheltenham Youth Center, J. DeWeese Carter Children's Center, Eastern Shore Structured Shelter Care, the Lower Eastern Shore Children's Center, Mount Clare House, and the Catonsville Guide Program in Baltimore City. Previously, Ms. Bones served as Grievance Supervisor investigating staff and inmate grievances in the York County, PA., Prison. She also served as a Hearing Officer on the Disciplinary Hearing Board. Ms. Bones completed an internship in a North Carolina State juvenile detention facility and has also worked in a number of residential and community based programs in Maryland and Pennsylvania, including electronic monitoring. She has a Bachelor of Arts degree from North Carolina Central University.

Timothy Snyder, Juvenile Justice Monitor, works with facilities in Western Maryland. He is assigned to the Allegany County Girls' Home, the four Youth Centers, the Western Maryland Children's Center, The Alfred Noyes Children's Center and the William Donald Schaefer House in Baltimore City. Mr. Snyder has a Master of Arts degree in Pastoral Counseling with special emphasis in marriage and family counseling from LaSalle University. Mr. Snyder was the Director of the New Dominion School in Maryland for eleven years. New Dominion School is an adventure based residential program for troubled youth. Mr. Snyder also worked in direct care and family services at New Dominion School in Virginia. He served as a consultant to families experiencing difficulties with their children prior to joining the Office of the Independent Juvenile Justice Monitor.

Phyllis Polston, Legal and Compliance Administrative Assistant, provided ongoing support and coordination for the activities of the Office of the Independent Juvenile Justice Monitor and the Assistant Attorney General for GOCYF. Her position was eliminated with the sunset of Article 49D.

ASSIGNED DJS FACILITIES

<u>FACILITY</u>	<u>LOCATION</u>	<u>MONITOR</u>
Allegany Girls Group Home	Allegany County	Tim Snyder
Green Ridge Youth Center	Allegany County	Tim Snyder
Thomas J. S. Waxter Children's Center	Anne Arundel County	Kim Bones
Baltimore Juvenile Justice Center	Baltimore City	Jeff Merson
Ferndale Group Home	Baltimore City	Closed
Maryland Youth Residence Center	Baltimore City	Jeff Merson

Mount Clare House	Baltimore City	Kim Bones
William Donald Schaefer House	Baltimore City	Tim Snyder
Guide Northeast Shelter Home	Baltimore County	Kim Bones
Charles H. Hickey, Jr. School	Baltimore County	Jeff Merson
Thomas O'Farrell Youth Center	Carroll County	Jeff Merson
Sykesville Group Shelter Home	Carroll County	Jeff Merson
Eastern Shore Structured Shelter Care	Dorchester County	Closed
Victor Cullen Academy	Frederick County	Closed
Backbone Mountain Youth Center	Garrett County	Tim Snyder
Meadow Mountain Youth Center	Garrett County	Tim Snyder
Savage Mountain Youth Center	Garrett County	Tim Snyder
J. DeWeese Carter Children's Center	Kent County	Kim Bones
Alfred D. Noyes Children's Center	Montgomery County	Tim Snyder
Cheltenham Youth Facility	Prince George's County	Kim Bones
Hagerstown Holdover Program	Washington County	Closed
Western Md. Children's Center	Washington County	Tim Snyder
Lower Eastern Shore Children's Center	Wicomico County	Kim Bones

OFFICE ACTIVITIES FOR FISCAL 2005

VISITATION

As illustrated in the preceding chart, monitors are assigned to specific facilities. The monitors are deployed on a regional basis in order to maximize the level of visitation. The monitors also make team visits as needed. Many visits by monitors occur on evenings and/or weekends when there is a higher incidence of problems. Most visits are unannounced. Also, monitors make more frequent visits to the larger, physically secure facilities due to the higher incidence of issues within these programs. During FY 2005 the Office of the Independent Juvenile Justice Monitor made 414 visits to 19 facilities. (see Appendix B).

During visits, monitors interview both youth and staff. In addition, monitors review facility records including cottage logs, grievance reports, incident reports, suicide watch forms, medical data, and staffing assignments. Further, monitors make inspections of the facilities to determine the status of the physical plant.

Facility Advisory Boards exist in some of the Department of Juvenile Services facilities. These councils are comprised of members of the community and local governing bodies who are charged with making recommendations to State Advisory Board and the

Secretary of DJS to improve the conditions within these facilities. The monitors attend and participate in these meetings on a regular basis.

REPORTING

Based upon the monitors' visitation to facilities, written reports are developed and submitted. Timely visitation reports are issued to the Children's Cabinet, the Secretary of the Department of Juvenile Services, and the Executive Director of the Governor's Office for Children, the Speaker of the House, and the President of the Senate generally on a quarterly basis. Special visitation reports detailing significant events are occasionally issued on a more frequent basis as circumstances dictate.

Both types of reports contain a corrective action plan noting the monitor's findings and recommendations. The Department of Juvenile Services is charged with completing this corrective action plan to address and remedy the issues cited. The Office of the Independent Juvenile Justice Monitor reviews the corrective action to determine if the stated plan properly addresses the issues cited. If, in the opinion of the Office of the Juvenile Justice Monitor, the plan fails to adequately address the issues cited, the corrective action plan is returned to the Department of Juvenile Services with comment and a request to amend. The Department of Juvenile Services then resubmits the corrective action plan. If the Office of the Independent Juvenile Justice Monitor and the Department of Juvenile Services cannot reach agreement on the corrective action plan, the matter may be referred the Executive Director of the Governor's Office for Children and Secretary of the Department of Juvenile Services for resolution.

In addition to the Timely Reports, the Office of the Independent Juvenile Justice Monitor issues Quarterly Reports, a summarized version of the findings and recommendations contained in the Timely Reports. The Quarterly Reports also contain the Department of Juvenile Services' responses to the Office of the Independent Juvenile Justice Monitor's findings and recommendations.

Finally, the Office of the Independent Juvenile Justice Monitor issues an Annual Report. Both the Quarterly Reports and the Annual Report may be accessed on the Internet at: www.goc.state.md.us.

- (1) The Office shall report in a timely manner to the Children's Cabinet, the Executive Director, the Secretary, and in accordance with §2-1246 of the State Government Article, the Speaker of the House of Delegates and the President of the Senate:
 - (a) Knowledge of any problem regarding the care, supervision, and treatment of children in facilities;
 - (b) Findings, actions, and recommendations, related to the investigations of disciplinary actions, grievances, incident reports, and alleged cases of child abuse and neglect; and
 - (c) All other findings and actions related to the monitoring required under this subtitle.

- (2) The Office shall report quarterly to the Executive Director, the Children's Cabinet, and the Secretary.
- (3) A copy of the report shall be provided to the State Advisory Board for Juvenile Services and, in accordance with §2-1246 of the State Government Article, the General Assembly.
- (4) The report shall include:
 - (a) All activities of the Office;
 - (b) Actions taken by the Department resulting from the findings and recommendations of the Independent Monitor, including the Department's response; and
 - (c) A summary of any violations of the standards and regulations of the Department that remain unabated for 30 days or more during the reporting period.
- (5) On or before November 30 of each year, the Office shall report to the Executive Director.

In addition, a Standard Operating Procedure (SOP) between the Office of the Independent Juvenile Justice Monitor and the Department of Juvenile Services was ratified in November 2003. Consistent with the provisions of the Executive Order, the SOP includes the criteria and standards used in monitoring facilities, the monitoring process itself, the sharing of information between DJS and the Independent Monitor, and the methods of documentation and reporting to the Secretary of DJS and the Children's Cabinet (See Appendix B). Please see Appendix C for a flow chart illustrating the reporting requirements of the Office of the Independent Juvenile Justice Monitor as required by the Executive Order and the Standard Operating Procedure.

REVIEW OF DJS INCIDENT AND INVESTIGATIVE REPORTS

The Department of Juvenile Services maintains a system wide incident reporting database, which the Office of the Independent Juvenile Justice Monitor may access via the Internet. Monitors regularly review this database as well as other reports and information resulting from their visits. In addition, the Office of the Independent Juvenile Justice Monitor obtains hard copies of the submitted incident reports that include supplemental information such as witness statements. Subsequently, DJS provides the Office of the Independent Juvenile Justice Monitor with copies of completed investigative reports. The information gathered from the review of the incident reporting process and the investigative reports allows monitors to determine whether accurate information is being collected by the Department regarding facility operations, assists in the collaboration with the Department's internal monitoring and investigation division (Office of Professional Responsibility and Accountability – OPRA), and helps identify potential trends within facilities.

GRIEVANCE REVIEW

Monitors, during their facility visitation, discuss with youth their knowledge of and satisfaction with the Department of Juvenile Services' grievance process. The Department of Juvenile Services assigns Child Advocates to facilities who review and process youth grievances. If a youth has not forwarded a grievance to the assigned Child Advocate, the monitor will normally encourage him/her to do so or make the referral on behalf of the youth. Monitors also regularly dialogue with the Child Advocates regarding activities and concerns within the facilities.

LEGISLATIVE AND POLICY ADVOCACY

The Office of the Independent Juvenile Justice Monitor, as part of the Governor's Office for Children has the opportunity to review and offer comment on proposed legislation impacting youth.

CHILD ABUSE AND NEGLECT

Abuse of youth within residential settings has been a particular concern of this Office. In its monitoring activity, this Office has identified numerous issues associated with the system of reporting, investigation, and disposition of allegations involving the abuse and neglect of youth within residential settings. Not all cases of suspected child abuse are being reported to the proper authorities and there have been some coordination problems between the Department of Juvenile Services, local Departments of Social Services and the appropriate law enforcement entity regarding their investigatory initiatives. Further, one agency may not know of the other's disposition of a case.

The Executive Order allows the Office of the Independent Juvenile Justice Monitor to receive notice from local Department of Social Services when an allegation of abuse and neglect is reported within one of this Office's assigned facilities. Further, this Office may participate in a multidisciplinary team process with the child protective services investigation.

In addition, in February 2004 the Maryland Attorney General issued an opinion in response to an inquiry by the Governor's Office for Children, Youth, and Families concerning the Office of the Independent Juvenile Monitor's function with regard to the reporting of child abuse and neglect. The Attorney General concluded that the Independent Monitor may, and should, include findings and recommendations regarding public agency performance in response to allegations of child abuse and neglect at DJS facilities while complying with appropriate law governing confidentiality. Further, the opinion held that so long as the Independent Monitor's report is in compliance with confidentiality requirements that the report may be subject to public inspection pursuant to a Maryland Public Information Act request.

The monitors have been instrumental in bringing together personnel from the local Department of Social Services, State Police, State's Attorney's Office, and Department of Juvenile Services to develop a draft protocol for the handling of allegations concerning

abuse and neglect in a number of jurisdictions. One such agreement, the Baltimore County Interagency Agreement on the Investigation of Child Abuse and Neglect at the Charles H. Hickey School, was signed by all concerned parties and enacted on April 22, 2004 and re-written to accommodate the State's takeover on July 1, 2004 (See Appendix E).

INTERAGENCY RELATIONS

The Office of the Independent Juvenile Justice Monitor has established productive working relationships with other youth-serving agencies and organizations. These agencies and organizations include:

- Detention Response Unit of the Baltimore Public Defender's Office
- Maryland Disability Law Center
- Suicide Prevention Network
- American Bar Association
- Annie E. Casey Foundation
- National Juvenile Detention Association
- American Correctional Association
- National Center on Institutions and Alternatives
- State Juvenile Justice Advisory Board
- State Juvenile Justice Advisory Councils
- Maryland State Police
- State's Attorney's Offices
- Maryland Association of Resources for Families and Youth
- Maryland Juvenile Justice Coalition
- Local Management Boards
- Local Departments of Social Services

ACCOMPLISHMENTS

- Staff from the Office of the Independent Juvenile Justice Monitor attended and participated in numerous statewide boards, workgroups and committees. A summary includes:
 - Juvenile Justice Advisory Board
 - Out of Home Legislative Workgroup
 - Interagency Institutional Abuse Workgroup
 - DJS Commitment Care Standards Committee
 - DJS Due Process Development Workgroup
 - Task Force to Study Alternative Living Arrangements for Children in Out of Home Placements
 - Youth Centers' Citizen Advisory Committee

- Maryland Female Taskforce
 - Detention Reform Committee
 - Task Force to Study the Mentoring and Monitoring of Children in the Custody of or Under the Supervision of DJS
 - Restraint and Seclusion Task Force
 - Children’s Justice Act Committee
 - Child Abuse Multidisciplinary Teams
- Initiated and coordinated efforts to develop and/or update Institutional Child Abuse Response Protocol Agreements between local Child Protective Services, the Maryland State Police, the Department of Juvenile Services and juvenile facilities in the counties of Baltimore (Hickey), Montgomery (Noyes), Anne Arundel (Waxter), Prince Georges (Cheltenham), Carroll (Thomas O’Farrell and Sykesville Shelter) and Baltimore City (Baltimore city Juvenile Justice Center)..
 - Provided eight (8) six-hour training modules on Child Abuse and Neglect Recognition and Reporting and eight (8) two-hour training modules on Juvenile Rights for approximately 250 new employees of the Department of Juvenile Services. Provided four (4) two-hour training modules for refresher training on Child Abuse and Neglect Recognition at local facilities for approximately 50 employees of the Department of Juvenile Services. These entrance level and in-service training courses are certified through the Maryland Police and Corrections Training Commission.
 - Presented a training module on Interagency Response to Institutional Child Abuse and Neglect at the Governor’s 12th Annual Conference on Child Abuse and Neglect.
 - Partnered with DJS to have the National Juvenile Detention Association conduct a staff training needs assessment at the Cheltenham Youth Facility and the Charles H. Hickey School. Subsequently, the National Juvenile Detention Association developed and provided a training curriculum to Cheltenham staff.
 - Issued several special reports outlining findings and recommendations in response to significant incidents within Department of Juvenile Services’ facilities.
 - Recommended numerous physical plant enhancements, which were completed.

FINDINGS AND RECOMMENDATIONS AND DEPARTMENT OF JUVENILE SERVICES ACTIONS

The Office of the Independent Juvenile Justice Monitor (OIJJM) submitted several Special Timely Reports during the fiscal year. On February 1, 2005, the Office became aware of allegations concerning child abuse at the Alfred D. Noyes Children's Center (Noyes). The Office notified the Department of Juvenile Services (DJS) Office of Professional Responsibility and Accountability (OPRA) and the local Department of Social Services (DSS). The Montgomery County Police Department (MCPD) also opened an investigation into the allegation. The agencies involved worked cooperatively and shared the information gathered in accordance with Article 88 6(b), which allows for sharing of reports or records concerning child abuse or neglect. On March 28, 2005, the Office of the Independent Juvenile Justice Monitor issued a Final Special Timely Report documenting a number of child abuse allegations at Noyes. Subsequently the Department of Juvenile Services, in accordance with established protocol, submitted a Corrective Action Plan with regard to the findings and recommendations contained in the Final Special Timely Report.

On August 26, 2004 and on March 2, 2005 Special Timely Reports were completed on the Baltimore Juvenile Justice Center by the monitoring team. Priority concerns were physical plant issues, the use of seclusion and other life, health and safety issues on August 26. Concerns raised in the March 2 report included safety and security of the facility, sufficient staffing and police response following an escape attempt. The facility has been repeatedly cited for not having the second tier railings covered or some type of barrier between the serving line and the kitchen area to protect staff persons and other youth. Several youth tied off on the railings attempting to hang themselves from the railings and staff had to hold them up by their legs and untie them to prevent them from completing their acts. There have been no recent incidents of youth attacking kitchen staff or gaining access to knives or other dangerous implements, but a barrier is still needed to prevent such actions. The lack of sufficient staffing impacts the ability of this facility to provide adequate programming and youth do not have a reasonable expectation of safety. Although the Department's Office for Professional Development and Training has worked extremely hard and increased efforts to train staff regarding proper restraint and crisis intervention techniques, some staff persons continue to provide very poor role modeling for the youth and have been administratively and criminally charged for abusing the youth at the facility. Seclusion has also been improperly used for punishment purposes rather than the removal of youth who are an imminent danger to themselves or others and appropriately processing them back into the facility's population.

The Office of the Independent Juvenile Justice Monitor's Quarterly Report (see appendix F) covering April – June 2005 provides a current summary of issues by facility and the Department of Juvenile Services' reported actions.

OUTSTANDING ISSUES AND RECOMMENDATIONS

DETENTION OVERCROWDING AND INADEQUATE STAFFING

- Overpopulation results from excessive admissions and prolonged lengths of stay, due largely to youth pending permanent placement.
- Populations exceed budgeted capacity and architectural design and create inadequate staffing ratios.
- Staffing is inadequate in facilities to provide a reasonable expectation of safety for youth.
- Life, health and safety issues persist in many facilities, imperiling both youth and staff.
- Youth are often idle, especially during weekends and evenings, when staffing is minimal.
- The Department of Juvenile Services has often cited that it does not control admission to detention and therefore, is unable to alleviate overcrowding. Most juvenile correctional agencies throughout the county share this problem. However, many juvenile correctional agencies have been able to develop partnerships and strategies that have been successful in reducing detention overcrowding.
- DJS should continue the implementation statewide of its intake risk assessment tool to screen for detention admission.
- Shelter placements and other community alternatives to detention should also be initiated.

CHILD ABUSE

While progress in the identification, reporting, investigation and disposition of residential child abuse and neglect allegations has been made, continued focus on this matter must occur. The Baltimore County Interagency Agreement addressing roles and responsibilities in the reporting and investigation of allegations of abuse and neglect at the Charles H. Hickey School has served as a model for other jurisdictions (See Appendix E). However, the rate of abuse and neglect continues at unacceptable levels in DJS facilities. A coordinated and comprehensive approach by all responsible agencies is required in order to appropriately address this issue.

CONTINUED ASSAULTS

A high incidence of youth-on-youth and youth-on-staff assaults continues in larger facilities. The volume of incident reports and grievances taxes the ability of DJS to process and investigate completely while underreporting of incidents at Cheltenham, Noyes and the Baltimore City Juvenile Justice Center continues to occur. DJS lacks quality control procedures in many facilities and this Office has repeatedly recommended the installation of video monitoring equipment and more managerial reviews of operations.

USE OF SECLUSION

Seclusion has often been used inappropriately and has been poorly processed. Detention facilities on the Eastern Shore and in Western Maryland use seclusion rather sparingly while the Baltimore City Justice Center continues to use seclusion on a more regular basis.

SUICIDE POLICY

The suicide prevention policy and procedure has not been fully and consistently implemented. DJS has violated its own policy and procedure by being able to adequately screen, refer and supervise suicidal youth. Also, many youth with severe mental health issues remain in DJS facilities, which are not equipped to appropriately serve this population. Facility practice must comply with adopted policy and procedure in order to ensure the safety of youth. Alternative resources are required to appropriately address this problem.

LACK OF STAFF TRAINING

A lack of training for both line and supervisory staff contributes to the problems within DJS facilities. The National Juvenile Detention Association conducted a staff training needs assessment at BCJJC, Cheltenham and Hickey last year and at Waxter this year.

OVER-RELIANCE ON STATE OPERATED RESIDENTIAL CARE PROGRAMS

Localities have little or no responsibility to provide services to youth involved in the juvenile justice system. For youth requiring services beyond what may be available by non-profit or other small organizations within a jurisdiction, the court system must rely upon committing a youth to the custody of the Department of Juvenile Services even if the court wishes to have the youth placed in a group home, which should be an extension of the local community and affiliated social and educational services. Youth only requiring more structured community programming and not secure placement are then usually placed in a detention facility such as Cheltenham and Hickey pending DJS processing and, hopefully, eventual placement in a group home should space be found. This results in youth being unnecessarily detained, minimally delinquent youth being exposed to severely delinquent youth, overcrowding in detention, prolonged time in finding placements, inappropriate placements occurring due to the system relying upon first available vacant bed regardless of the youth's needs, and youth not being placed closer to family and other support systems.

The system must be redesigned to create more local, community programs and viable options outside of state care for the juvenile court. A number of states have created such incentives for local jurisdictions and maximized community programming and services.

Such expanded local programming could also occur in Maryland with limited fiscal impact. Maryland is already expending a significant portion of funding for juvenile services but with a disproportionate amount designated for detention and deep end residential care. With limited venture capital to initiate new services within localities, a determination of what the state expended for a particular locality for detention and other residential care could be calculated, and these funds could be administered locally with

the court/locality deciding how it wished to expend its funds in providing services to youth. Local control of funding would create incentives to develop less expensive options for treatment of youth and reach youth at earlier stages in the judicial process with an increased chance for success.

ANTIQUATED AND POORLY DESIGNED FACILITIES

Many facilities are antiquated and functionally obsolete. The newly constructed facilities, Baltimore City Juvenile Justice Center, Lower Eastern Shore Children's Center, and Western Maryland Children's Center, all have significant physical plant deficiencies that pose safety concerns for both youth and staff. These issues not only impact the ability to deliver services but create public safety concerns due to the lack of security. There have been a number of escapes this year from Cheltenham, Hickey, Noyes, Waxter, and the Baltimore Juvenile Justice Center. In addition, youth in the newer facilities have damaged or destroyed non-security grade fixtures using these items in suicide attempts and/or as weapons. The capital improvement plan for these facilities should take into account the need to renovate and consolidate the footprint of structures to improve operations and security/supervision.

STANDARDS

A comprehensive set of standards governing Department of Juvenile Services, both for secure and non-secure facilities, is still lacking. Department of Juvenile Services standards for secure detention were revised on Feb. 1, 2004. These standards do not cover many of the requirements addressed in nationally recognized standards and only govern secure detention facilities. Standards do not exist for Department of Juvenile Services operated facilities such as short-term shelters, group homes, and commitment care programs. Further, DJS operated facilities are exempt from complying with COMAR standards to which privately operated programs must adhere. Adoption of nationally recognized standards or use of other states' standards could be put into place in an expeditious manner. To date, the Department of Juvenile Service has not established or adopted such standards. This allows substandard conditions to perpetuate creating serious life, health, and safety issues.

APPENDICES

Appendix A – Executive Order Establishing the OIJM under GOC Effective July 1, 2005

Appendix B – Visitation Chart

Appendix C – Standard Operating Procedure

Appendix D – Flow Chart

Appendix E – Amended Baltimore County Interagency Agreement on the Investigation of Child Abuse and Neglect at the Charles H. Hickey School

Appendix F – Quarterly Report for April through June 2005

APPENDIX A
Executive Order
01.01.2005.35

EXECUTIVE ORDER
01.01.2005.35

Office of the Independent Juvenile Services Monitor

WHEREAS, The Office of the Independent Juvenile Justice Monitor was established through a memorandum of agreement between the then Department of Juvenile Justice and the Governor's Office of Children, Youth, and Families in 2000. It was codified in Article 49D of the Annotated Code of Maryland by Chapter 255 of 2002 and placed within the Office of Children, Youth and Families;

WHEREAS, Article 49D will sunset on June 30, 2005;

WHEREAS, The General Assembly passed House Bill 1342 - Juvenile Justice Monitoring - Transfer to Office of the Attorney General to transfer all duties of the Office of the Independent Juvenile Justice Monitor from the Office of Children, Youth, and Families to the Office of the Attorney General;

WHEREAS, Under House Bill 1342, the Attorney General would have been placed in the position of having employees of one unit within the office testifying against a department represented by another employee within the office, thereby presenting conflicts which could have jeopardized the integrity of the State's effort to ensure that our juvenile facilities are operated in compliance with federal and State law; accordingly, the Governor vetoed House Bill 1342; and

WHEREAS, It is imperative that we ensure our juveniles are housed and treated in ways which will both protect public safety and present the best opportunities for rehabilitation and reduced recidivism. Therefore, it is appropriate to re-establish the Office of Independent Juvenile Justice Monitor and locate the Office within the Governor's Office for Children.

NOW, THEREFORE, I, ROBERT L. EHRLICH, JR., GOVERNOR OF THE STATE OF MARYLAND, BY VIRTUE OF THE AUTHORITY VESTED IN ME BY THE CONSTITUTION AND LAWS OF MARYLAND, HEREBY PROCLAIM THE FOLLOWING EXECUTIVE ORDER, EFFECTIVE IMMEDIATELY:

A. Definitions. The following words have the meanings indicated.

1. "Children's Cabinet" means the Children's Cabinet established by Executive Order 01.01.2005.34.
2. "Director" means the Director of the Office of the Independent Juvenile Services Monitor.

3. "Disciplinary action" means any punitive action against a child that results in more security, additional obligations, or less personal freedom.
 4. "Department" means the Department of Juvenile Services.
 5. "Executive Director" means the Executive Director of the Governor's Office for Children.
 6. "Facility" means:
 - a. A residential facility operated by the Department; and
 - b. A residential facility owned by the Department but privately operated.
 7. "Grievance" means a complaint made by a child or on behalf of a child due to a circumstance or action considered to be unjust. "Grievance" does not include an employee grievance, disciplinary appeal, or complaint.
 8. "Independent Juvenile Services Monitor" means the Director of the Office of the Independent Juvenile Services Monitor and any individual designated by the Director to determine whether the needs of children under the jurisdiction of the Department are being met in compliance with State law, that their rights are being upheld, and that they are not being abused.
 9. "Office" means the Office of the Independent Juvenile Services Monitor.
 10. "Secretary" means the Secretary of Juvenile Services.
- B. Established. There is an Office of the Independent Juvenile Services Monitor as an independent unit in the Governor's Office for Children
- C. Organization.
1. The Office shall include a full-time Director and staff as provided in the State budget.
 2. All salaries for the Director and independent juvenile justice monitors and expenses for rent, equipment, supplies, and general operating expenses necessary for the work of the Office shall be as provided in the State budget.

3. In cooperation with the Secretary of Budget and Management, the Director shall set minimum salaries, qualifications, and standards of training and experience for positions with the Office.

D. Duties and Responsibilities.

1. The Office shall:

- a. Evaluate at each facility:

- i. The child advocacy grievance process;
- ii. The Department's monitoring process;
- iii. The treatment of and services to youth;
- iv. The physical conditions of the facility; and
- v. The adequacy of staffing.

- b. Review all reports of disciplinary actions, grievances, and grievance dispositions received from each facility and alterations in the status or placement of a child that result in more security, additional obligations, or less personal freedom;

- c. Receive copies of the grievances submitted to the Department;

- d. Perform unannounced site visits and on-site inspections of facilities;

- e. Receive and review all incident reports submitted to the Department from facilities;

- f. Receive reports of the findings of child protective services investigations of allegations of abuse or neglect of a child in a facility; and

- g. Be available to attend meetings of the advisory boards established under Article 83C, § 2-119 of the Code.

2. The Office may:

- a. Review relevant laws, policies, procedures, and juvenile justice records, including records relating to individual youth;

- b. On request, conduct interviews with staff, youth, and others;
- c. Review investigative reports produced by the Department relating to youth in facilities; and
- d. Participate, within the context of the local department of social services' multidisciplinary team process, in a child protective services investigation conducted under Title 5, Subtitle 7 of the Family Law Article concerning any allegation of abuse or neglect within any assigned facility.

3. Reports.

- 1. The Office shall report in a timely manner to the Children's Cabinet, the Executive Director, the Secretary, and in accordance with § 2-1246 of the State Government Article, the Speaker of the House of Delegates and the President of the Senate:
 - a. Knowledge of any problem regarding the care, supervision, and treatment of children in facilities;
 - b. Findings, actions, and recommendations, related to the investigations of disciplinary actions, grievances, incident reports, and alleged cases of child abuse and neglect; and
 - c. All other findings and actions related to the monitoring required under this Executive Order.
- 2. The Office shall report quarterly to the Executive Director, the Children's Cabinet, and the Secretary.
- 3. A copy of the report shall be provided to the State Advisory Board for Juvenile Services and, in accordance with § 2-1246 of the State Government Article, the General Assembly.
- 4. The report shall include:
 - . All activities of the Office;
 - a. Actions taken by the Department resulting from the findings and recommendations of

the Independent Juvenile Services Monitor,
including the Department's response; and

- b. A summary of any violations of the standards and regulations of the Department that remain unabated for 30 days or more during the reporting period.
5. On or before November 30 of each year, the Office shall report to the Executive Director.

GIVEN Under My Hand and the Great Seal of the State of Maryland, in the City of Annapolis, this 9th Day of June, 2005.



Robert L. Ehrlich, Jr.
Robert L. Ehrlich, Jr.
Governor

Attest:

R. Karl Aumann
R. Karl Aumann
Secretary of State

APPENDIX B
Visitation Chart

**2004-2005 VISITATION BY THE
OFFICE OF THE INDEPENDENT JUVENILE JUSTICE MONITOR**

FACILITY	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TTL	
ALLEGANY GIRLS HOME	1	2	2	2	3	2	1	1	2	1	1	1	19	
BALT. CITY JUVENILE JUSTICE CENTER	4	11	18	2	3	2	2	4	2	2	2	3	57	
CARTER	2	2	1	2	1	2	1	1	1	1	2	1	17	
CATONSVILLE SHELTER	1	1	1	1	1	1	2	1	1	1	1	1	13	
CHELTENHAM	3	2	5	3	3	4	2	2	1	2	3	1	31	
HICKEY	3	3	3	1	3	1	2	3	1	1	2	1	24	
LOWER EASTERN SHORE CHILDREN'S CENTER	1	1	1	1	2	1	2		2	1	1		13	
MD. YOUTH RESIDENCE CENTER	4	2	3	3	3	2	1	2	1	1	1	1	24	
MOUNT CLARE HOUSE	2	2	3	2	2	2	1	1	1	1	1		18	
NOYES	2	1	1	1	1	1	1	6	3	2	5	1	22	
THOMASO'FARRELL YOUTH CENTER	1	2	2	1	3	1	2	1	1	1	2	1	18	
WM. DONALD SHAEFER HOUSE	2	2	2	2	2	2	1		1	1	1	1	17	
SYKESVILLE SHELTER	1	1	1	1	1	1	1	2	1	1	1	1	13	
THOMAS WAXTER	1	3	2	1	2	1	2	2	2	2	2	1	21	
YOUTH CENTERS														
Green Ridge Savage Mtn. Meadow Mtn. Backbone Mtn.	1	1	2	2	1	2	2	1	1	2	1	2	1	18
	2	1	2	2	1	2	2	1	1	2	1	2	1	18
	3	1	3	1	1	2	1	1	1	2	1	1	1	16
	4	1	2	2	1	2	2	2	1	2	1	1	1	18
W. MD. CHLDRNS CNTR	4	2	3	3	4	3	3	4	4	2	1	3	36	
TOTALS	36	46	55	30	42	33	29	34	32	24	32	21	414	

APPENDIX C
Standard Operating Procedure

**GOVERNOR’S OFFICE FOR CHILDREN, YOUTH, AND FAMILIES
AND
DEPARTMENT OF JUVENILE SERVICES
STANDARD OPERATING PROCEDURES
FOR THE
INDEPENDENT JUVENILE JUSTICE MONITOR**

1.0 Background:

In February 2000, the Maryland Subcabinet for Children, Youth, and Families and the Maryland Department of Juvenile Services (DJS) signed a Memorandum of Agreement (MOA) establishing an Independent Monitor for the Department of Juvenile Justice. A revised Memorandum of Agreement took effect on November 1, 2001. Effective October 1, 2002, the Office of the Independent Monitor was codified under the terms of HB 971, Chapter 255, Laws of Maryland 2002. The Independent Monitor evaluates at each facility the Child Advocacy Grievance process, the DJS monitoring process, the treatment of and services provided to youth at each facility, the physical condition of each facility, and the adequacy of staffing.

2.0 Purpose:

This document outlines the Standard Operating Procedures (SOP) for implementation of the provisions of Chapter 255 and the Independent Monitor MOA by DJS and OCYF. The SOP includes the criteria and standards used in monitoring facilities, the monitoring process itself, the sharing of information between DJS and the Independent Monitor, and the methods of documentation and reporting to the Secretary of DJS and the Subcabinet.

3.0 Definitions:

- 3.1** “Child Advocate” means an individual who works on behalf of youth under the DJS jurisdiction to ensure youth needs are met and their rights upheld throughout DJS operations.
- 3.2** “Corrective Action Plan” means a plan developed by DJS and a DJS facility to address findings and recommendations of the Independent Monitor related to that facility.
- 3.3** “Grievance” means a complaint by or on behalf of a youth concerning a circumstance or action alleged to be unjust. “Grievance” does not include an employee grievance, disciplinary appeal, or complaint.
- 3.4** “Independent Monitor” means the Independent Monitor for Juvenile Justice or a member of the staff of the Independent Monitor for Juvenile Justice.
- 3.5** “Monitoring” means the process of assessing performance in accordance with the provisions of Section 4.0.
- 3.6** “Facility” means a residential facility owned or operated by DJS. A residential facility is a program that provides residential services to youth on a 24-hour basis.
- 3.7** “Youth” means an individual who is under the jurisdiction of DJS and placed in a facility.

4.0 Monitoring Standards:

4.1 Existing Standards

The Independent Monitor shall monitor using the following standards:

4.1.1 Code of Maryland Regulations (COMAR)

- Title 01 Executive Department, Subtitle 04 Office for Children, Youth, and Families, Chapter 04 Residential Child Care Programs.
- Title 07 Department of Human Resources, Subtitle 02 Social Services Administration, Chapter 07 Protective Services for Neglected and Abused Children.
- Title 16 Department of Juvenile Services.

4.1.2 DJS Secretary Directives and DJS Protocol, Procedure and Guidelines

DJS Secretary's Directives, protocols, procedures, and guidelines governing the care, custody, treatment and supervision of youth at facilities monitored by the Independent Monitor. DJS will provide the Independent Monitor with copies of directives protocols, procedures, and guidelines for inclusion among the Independent Monitor's compliance standards.

4.1.3 DJS Standards for Juvenile Detention Facilities

This volume describes in detail the requirements for operating a detention facility. Though not all facilities that the Independent Monitor reviews are used for detention, many of the standards may apply to other types of residential facilities.

4.1.4 DJS Standards of Conduct and Disciplinary Process

This volume contains rules for DJS employee conduct, attendance and leave, disciplinary sanctions, appeals and grievances, and information about the Investigations and Child Advocacy Unit (ICAU), including: Standards of Conduct and Performance; Attendance Requirements; Disciplinary Sanctions; Implementation of Corrective and Disciplinary Sanctions; Appeals and Grievances; Investigation and Child Advocacy Unit.

4.1.5 Contracts between DJS and private entities

Upon request, DJS shall provide the Independent Monitor with access to or a copy of a contract for the operation of a facility.

4.1.6 Court Orders

Upon request, DJS shall provide the Independent Monitor with copies of relevant court orders. The Independent Monitor shall review such orders when monitoring

4.2 Identification of relevant standards

DJS will provide the Independent Monitor with citations to all statutes and regulations, and copies of all relevant policies, procedures, court orders and contract provisions that it has determined are relevant to the monitoring process. DJS and the Independent Monitor will work collaboratively in identifying revisions and additions to these standards.

4.3. Identification of Other Monitoring Concerns

As part of monitoring whether facilities are in compliance with the standards identified in Sections 4.1 and 4.2, the Independent Monitor may also address other conditions and situations that jeopardize the effectiveness of the DJS grievance and monitoring processes, the treatment of and services to youth at each facility, the physical condition of each facility, and the adequacy of staffing for which:

- A. no current standards applicable to DJS can be identified; or
- B. the Independent Monitor believes that current standards afford inadequate protection of the health, life, safety and humane treatment of youth in a DJS facility. If the Independent Monitor determines that current standards afford inadequate protection of the health, life, safety and humane treatment of youth in a DJS facility, the Independent Monitor shall identify the deficiency in current standards related to the concern and provide recommendations pursuant to Section 7.0. The Independent Monitor may report associated findings and recommendations in accordance with the reporting requirements in Section 6.1.

5.0 Monitoring Process:

The Independent Monitor has a formalized monitoring and reporting process to ensure that on-site visits to facilities result in identifying and reporting to the Secretary of DJS in a timely manner, any material deficiencies in treatment and services or immediate threats to the health, life, safety and humane treatment of youth under DJS care, custody or supervision.

5.1 The Independent Monitor may conduct unannounced and unscheduled visits to facilities.

5.2 The Independent Monitor shall develop and use monitoring tools for collecting and documenting information obtained during the on-site monitoring visit, including interviews, review of records, and observation.

5.2.1 The Special Secretary shall approve any monitoring tools used by the Independent Monitor.

5.2.2 The Secretary of DJS shall have the opportunity to provide input regarding the monitoring tools prior to approval by the Special Secretary and shall be given copies of all monitoring instruments.

5.2.3 The Independent Monitor shall revise monitoring tools to reflect revisions to DJS standards under Section 4.1.

5.2.4 To the extent they exist, DJS shall provide the Independent Monitor with copies of any monitoring tools utilized by the Investigations Unit of the DJS Office of Professional Responsibility and Accountability.

5.3 DJS and the Independent Monitor shall share information as follows:

5.3.1 The Independent Monitor may inspect any information that is readily accessible on site at a DJS facility or office upon request, and may make copies at that time, subject to immediately available resources.

5.3.2 The Independent Monitors shall have ongoing access to DJS electronic case tracking and incident reporting and tracking systems at the Independent Monitor's OCYF and field locations. DJS shall provide hard copies of attachments to incident reports upon the Independent Monitor's request.

5.3.3 DJS shall provide all incident reports, attachments to incident reports, and dispositions not available on the online system to the Independent Monitor on a weekly basis.

5.3.4 DJS shall provide the Independent Monitor with a copy of its monthly summary grievance report as part of the report's routine distribution, and copies of individual grievances and their dispositions upon the Independent Monitor's request.

5.3.5 DJS shall provide the Independent Monitor with copies of all investigative reports relating to youth in facilities within 3 days of each report's completion.

5.3.6 If DJS is required to compile information in order to meet a request of the Independent Monitor, the information shall be provided within 30 days.

5.4 The Independent Monitors shall announce their presence and sign in on the facility's log upon arrival at a facility. The Independent Monitor will be available to confer with the facility administrator at the administrator's request and to advise the administrator of the nature of the visit and the scope of the monitoring visit, as appropriate.

5.4.1 The administrator shall facilitate the cooperation of facility personnel and the identification of documentation to be reviewed, if any. Consistent with the safety and well being of staff and youth and the orderly operation of the facility, the administrator shall ensure that staff and youth are reasonably available to communicate with the Independent Monitor. If DJS staff indicates that an Independent Monitor's visit to a particular area creates a security risk, the Independent Monitor will temporarily leave the area. If DJS staff indicates they are not able to reasonably respond to the Independent Monitor's questions while assisting youth in their normal course of duty, the Independent Monitor may schedule an interview at a time when the staff is not working with youth.

5.5 The Independent Monitor shall immediately report imminent or material threats to the health, life, and safety of youth, staff, or the public to:

- The facility administrator or managing officer, as appropriate, and
- The DJS on call administrator.

5.5.1 At the conclusion of the on-site visit the Independent Monitor shall offer to conduct an exit conference with the facility administrator or managing officer to advise them of any preliminary findings and observations.

5.5.2 The Independent Monitor shall specifically advise the administrator

or managing officer of other issues that may have the potential to jeopardize the health, life, or safety of youth, staff, or the public.

5.6 As soon as practicable, DJS shall report imminent or material threats to the health, life, and safety of youth, staff, or the public to the Independent Monitor.

6.0 Reporting.

6.1 The Independent Monitor shall prepare preliminary findings and recommendations to the Secretary of DJS (or designee) on the results of a monitoring visit, including findings and recommendations regarding compliance with standards identified under Section 4.1 and other concerns identified under Section 4.3. The preliminary findings and recommendations shall be submitted and organized as follows:

6.1.1 Findings related to DJS's compliance with standards included in section 4.1 shall be reported in a section entitled "compliance with DJS standards."

6.1.2 Findings related to concerns regarding the adequacy of DJS standards under section 4.3 shall be reported in a section entitled "other monitoring concerns."

6.1.3 Recommendations related to compliance with DJS standards included in section 4.1 shall be reported in a section entitled "recommendations" and in proposed corrective action plan elements appended to the report.

6.1.4 Recommendations regarding options for addressing concerns identified under section 4.3 may be set out in a memorandum to the Special Secretary, as provided in section 7.0.

6.2 The Independent Monitor will submit preliminary reports of findings and recommendations regarding regular, periodic monitoring visits to facilities to DJS on at least a quarterly basis. In addition, the Independent Monitor may submit preliminary reports of specific incidents seriously affecting the care, supervision and treatment of children in facilities that require more timely attention at any time.

6.3 DJS will be permitted 10 work days from the date of hand delivery or facsimile receipt of a preliminary report to deliver a response to the preliminary report findings and recommendations, including suggested corrections or other revisions to the preliminary report and the reasons for those suggested changes. The Independent Monitor may seek further clarification or otherwise discuss the response with DJS. The Independent Monitor may amend the preliminary report to adopt any DJS suggestion, as appropriate. The preliminary report shall be considered a draft during the 10-day comment period.

6.3.1 If the Independent Monitor does not adopt a DJS suggestion, the DJS response to the preliminary report shall be appended to and considered a part of the Independent Monitor's Final Report of Findings and Recommendations. If some of the DJS suggestions are adopted, DJS shall

be given the opportunity to deliver a modified response, within 3 workdays from the date of hand delivery or facsimile notice of the Independent Monitor's decision, for inclusion with the Independent Monitor's Final Report of Findings and Recommendations.

6.3.2 If DJS does not deliver suggested corrections or revisions to the preliminary report within 10 workdays, the Independent Monitor's preliminary report shall be forwarded to DJS as the Final Report of Findings and Recommendations.

6.4 The Independent Monitor will send a copy of the Final Report of Findings and Recommendations to DJS, the Subcabinet, the Speaker of the House, and the President of the Senate within 10 workdays after the deadline for receipt of comments to the preliminary report.

6.5 DJS will have 45 days from receipt of the preliminary findings and recommendations to submit a Corrective Action Plan which details corrective actions taken since the date of the on-site visit and corrective actions to be taken, including timelines for completion.

6.6 To enhance the possibility of agreement as to the Corrective Action Plan, the Independent Monitor and DJS shall engage in discussions concerning DJS's proposed Corrective Action Plan.

6.7 Within 90 days of issuance of the Report of Findings and Recommendations, the Independent Monitor shall issue a Comprehensive Monitoring Report. The Comprehensive Monitoring Report shall include: the Final Report of Findings and Recommendations, the Corrective Action Plan and the following addenda, as appropriate:

6.7.1 If the Report of Findings and Recommendations does not adopt the suggestions contained in DJS's response to the preliminary report, it shall include a copy of DJS's response. If some of DJS's suggestions are adopted, DJS shall be given the opportunity to submit a modified response for inclusion with the Comprehensive Monitoring Report.

6.7.2 If DJS and the Independent Monitor have not reached agreement regarding the Corrective Action Plan, the Comprehensive Monitoring Report may include the Independent Monitor's comments on the DJS Corrective Action Plan.

6.8 If the Independent Monitor and DJS have not reached agreement on the Corrective Action Plan within the 90-day period, then the issues in dispute shall be submitted to the Secretary of DJS and the Special Secretary for resolution. However, efforts to resolve disputes under this provision shall not delay the issuance of the Comprehensive Monitoring Report within the 90-day timeline in Section 6.6.

6.9 The Independent Monitor's Comprehensive Monitoring Report shall be

distributed to the Secretary of DJS, the Subcabinet, the Speaker of the House, and the President of the Senate, and be made available in electronic format.

6.10 On the next visit to the facility, the Independent Monitor shall review the status of corrective action on items agreed to by DJS from the prior monitoring reports, in addition to other monitoring activities that may be appropriate.

6.11 All reports issued by the Independent Monitor shall comport with the provisions of this Section and Section 7.0.

7.0 Policy Recommendations.

If the Independent Monitor has recommendations regarding matters to be addressed pursuant to Section 4.3, those concerns or suggestions shall be presented in a memorandum to the Special Secretary. If the Special Secretary deems it appropriate, the Special Secretary may present such matters to the Secretary of DJS and the Subcabinet.

8.0 Confidentiality.

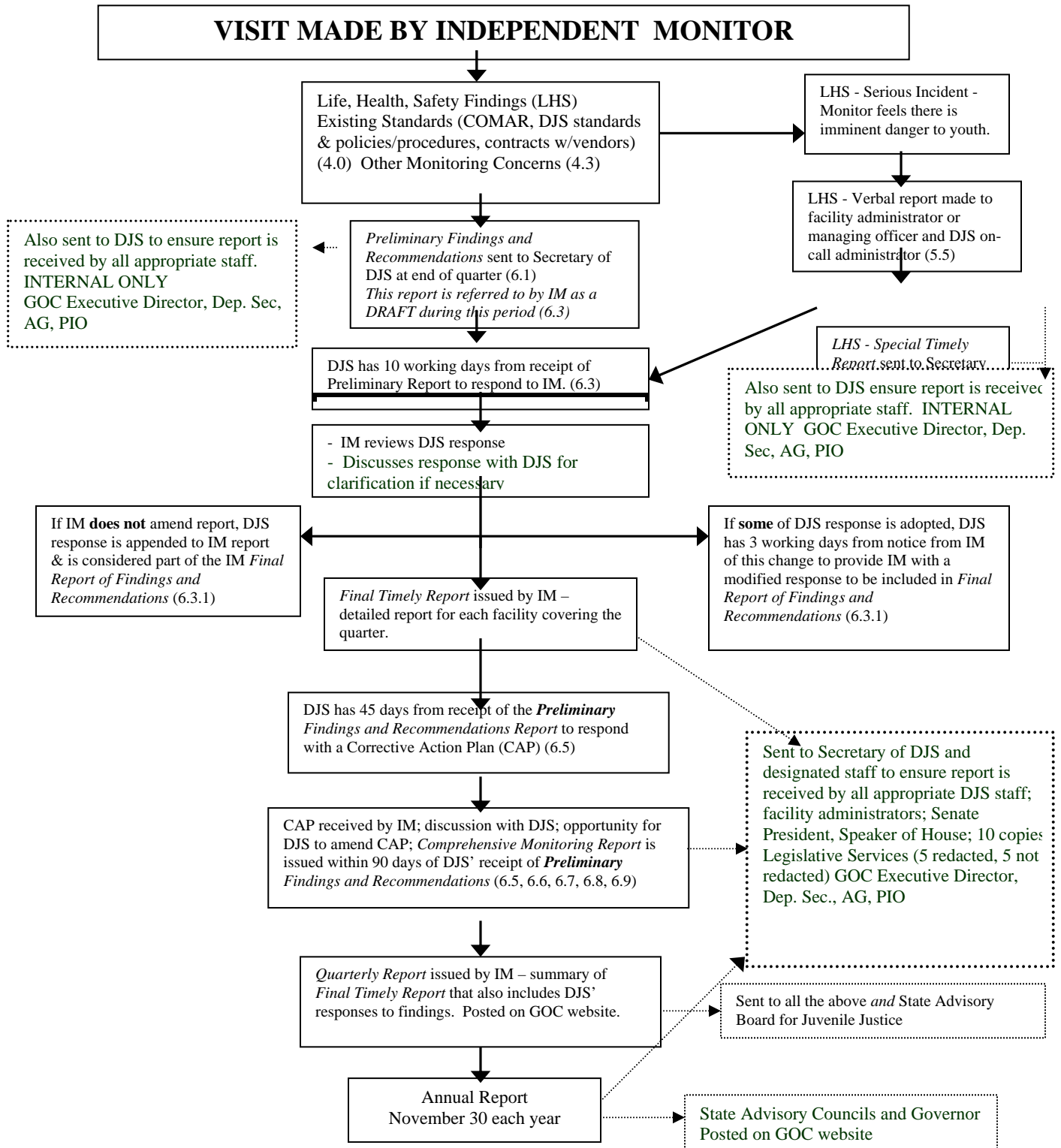
8.1 The Independent Monitor shall conduct the monitoring process and reporting consistent with applicable confidentiality laws, including, but not limited to, Maryland Annotated Code, Courts and Judicial Proceedings Article, § 3-8A-27, Article 83C, Article 88A, §6A, and Article 49D.

APPENDIX D
Flow Chart

Independent Monitoring and Reporting Process

Based on HB 971, Article 49D and agreed upon SOP from November 3, 2003

VISIT MADE BY INDEPENDENT MONITOR



APPENDIX E
**Amended Baltimore County Interagency
Agreement on the Investigation of Child Abuse
and Neglect at the Charles H. Hickey School**

**AMENDED BALTIMORE COUNTY INTERAGENCY AGREEMENT
ON THE INVESTIGATION OF CHILD ABUSE AND NEGLECT
AT THE CHARLES H. HICKEY, JR. SCHOOL**

I. GENERAL

The purpose of this Baltimore County Interagency Agreement on the Investigation of Child Abuse and Neglect at the Charles H. Hickey, Jr. School (agreement) is to provide and promote coordination and communication among the participating agencies in the investigation of allegations of child abuse and child neglect at the Charles H. Hickey, Jr. School and in any subsequent personnel actions or criminal prosecutions which might arise from such investigations. The goal of this agreement is to provide the best possible outcomes for children and the community. The parties agree to follow a common protocol for investigating allegations of child abuse and child neglect, to commit resources necessary to achieve common goals, to seek to resolve differences that arise between or among agencies, and to place the welfare of children first.

The participating agencies in this Agreement are the Baltimore County Department of Social Services (DSS), the Maryland State Police (MSP), the Office of the State's Attorney for Baltimore County (SAO), the Maryland Department of Juvenile Services (DJS), the Maryland State Department of Education (MSDE), and the Governor's Office for Children (GOC).

- DSS is responsible for conducting Child Protective Services (CPS) assessments of allegations of suspected child abuse and neglect at the Charles H. Hickey, Jr. School. DSS shall designate specific staff with appropriate skills and training to conduct these assessments.
- MSP is responsible for conducting criminal investigations of suspected child abuse at the Charles H. Hickey, Jr. School. MSP shall designate detectives with appropriate skills and training to conduct these investigations.
- SAO is responsible for the prosecution of criminal charges arising from investigations of suspected child abuse and neglect at the Charles H. Hickey, Jr. School.
- DJS is responsible for administrative investigations and for the care and welfare of the young persons in its legal custody at the Charles H. Hickey, Jr. School.
- MSDE is responsible for providing educational services at the Charles H. Hickey, Jr. School. MSDE shall designate specific staff with appropriate skills and training to provide educational services

and shall take appropriate personnel action regarding its staff or contractors in response to investigations of child abuse or neglect.

- GOC is responsible, through its Independent Juvenile Justice Monitor, for general oversight of the welfare of children in the custody of DJS, including residential students at the Charles H. Hickey, Jr. School.

II. CHILD ABUSE

The Initial Report.

DSS and MSP shall maintain 24-hour coverage for receiving reports of **all** suspected child abuse.

DSS and MSP shall immediately share with each other all information/notifications of suspected child abuse. Whenever either party receives a report, whether from an outside source or from the other, both parties shall also notify the Independent Juvenile Justice Monitor and DJS as soon as possible.

If the allegation involves an MSDE staff member, the MSDE principal or designee assigned to the Charles H. Hickey, Jr. School shall be notified and issued a copy of the initial DJS incident report within 24 hours of the reported incident.

The Independent Juvenile Justice Monitor and MSP shall also be notified by either DSS or DJS of any reports of alleged inappropriate conduct directed towards students at the Charles H. Hickey, Jr. School, even if such incidents do not meet the technical requirements of child abuse. An example would be an alleged assault by a Hickey School staff member against a student who is 18 years old or older. MSP shall promptly notify SAO of any criminal investigations arising from such circumstances.

DJS shall assist DSS, MSP and MSDE in obtaining basic information regarding the victim and the alleged perpetrator.

The Investigation.

All child victims shall be seen within 24 hours by the MSP, and/or DSS.

DSS and the MSP shall conduct joint investigations of suspected child abuse to the fullest extent circumstances permit. There shall be full sharing of information between the respective investigators. Whenever possible, the specialized investigators from DSS, MSP shall make a joint initial on-site response at the Charles H. Hickey, Jr. School.

If the alleged abuser is an MSDE staff member, DJS shall notify MSDE, whenever possible, of the time and date of the DSS and/or MSP interview with the staff member and victim and, if possible, attempt to coordinate the time of the

interview so that an MSDE investigator may be present at the facility. If the staff member and/or victim's parent, guardian or caregiver provides consent, the interviews may be audiotaped and/or videotaped. In the case of allegations of sexual misconduct against an MSDE staff member, all reasonable efforts will be made for the interviews to be conducted at the DSS and to arrange for the victim and any minor witnesses to be transported to and from the facility by the MSP. It will be the joint decision of DSS and MSP whether videotaping or audit taping is impractical or clinically or forensically inappropriate or contrary to the best interest of the youth.

If MSDE or DJS need to conduct interviews separate from those conducted by DSS and MSP a multi-disciplinary staffing that includes representatives of DJS, MSDE, DSS, and SAO shall be immediately held to share information and determine whether additional interviews of victims, staff or witnesses is appropriate or necessary. Regardless whether additional interviews are necessary all cases involving MSDE or DJS personnel shall be subject to a multi-disciplinary staffing within 30 days of the initial report to enable MSDE or DJS to take appropriate personnel action.

MSP patrol officers shall respond on-site to the Charles H. Hickey, Jr. School when necessary and after normal business hours to meet the mandate for 24-hour response.

In the event of serious injury after normal business hours, the MSP patrol officer shall notify an MSP detective who shall notify DSS through the DSS After Hours Service emergency telephone number. An MSP detective and the DSS social worker assigned to After Hours Service shall respond to the Charles H. Hickey, Jr. School to begin the investigative process. A specialized investigator from DSS shall take over the CPS portion of the investigation on the next business day.

DJS on-site investigators shall make medical, social and other relevant information under its control available to DSS and MSP investigators.

If the alleged perpetrator of the abuse is an MSDE employee or contractor, the DSS shall inform the MSDE Assistant State Superintendent of education or his or her designee immediately of the investigation. MSDE shall ensure that steps are immediately taken to remove the alleged abuser from direct contact with the victim and other children as necessary pending completion of the investigation. Further, DJS and MSDE shall take all necessary steps to protect the victim and any witnesses.

DJS shall assist in interviewing victims and suspects and gathering of relevant information from the facility at the direction of MSP, and/or DSS investigators. This may include taking photographs of alleged victims and/or alleged perpetrators.

DJS shall ensure that the victim receives appropriate medical and/or mental health treatment.

Whenever possible, DSS, and MSP shall coordinate all subsequent investigative interviews of victims, alleged perpetrators and other persons relevant to the investigation.

MSP, , DSS and DJS may consult with SAO if they believe that criminal or juvenile delinquency charges may result, or should result, from any incident under investigation at the Charles H. Hickey, Jr. School.

III. CHILD NEGLECT

The Initial Report.

DSS shall maintain 24-hour coverage for receiving reports of suspected child neglect.

DSS shall notify the Independent Juvenile Justice Monitor of GOC and DJS of any report it receives alleging neglect of a student at the Charles H. Hickey, Jr. School as soon as possible.

The Independent Juvenile Justice Monitor shall also be notified by DSS, MSP, MSDE or DJS of any reports of alleged inappropriate conduct directed towards students at the Charles H. Hickey, Jr. School, even if such incidents do not meet the technical requirements of child neglect.

DJS shall assist DSS in obtaining basic information regarding the victim and the alleged perpetrator.

The Investigation.

All child victims shall be seen within 5 days by DSS.

Whenever possible, DSS shall assign specialized staff to conduct CPS investigations at the Charles H. Hickey, Jr. School beginning with the initial on-site response.

DJS on-site investigators shall make medical, social and other relevant information under its control available to DSS.

If the alleged perpetrator of the neglect is an MSDE employee or contractor, DSS shall inform the MSDE Assistant State Superintendent of education or his or her designee immediately of the investigation. MSDE shall ensure that steps are immediately taken to remove the alleged perpetrator from direct contact with the victim and other children as necessary pending completion of the investigation. Further, MSDE and DJS shall take all necessary steps to protect the victim and any witnesses.

If the alleged perpetrator of the neglect is an MSDE employee or contractor, DSS and DJS shall attempt to coordinate the date and time of the interview with the staff member and victim so that an MSDE investigator may be present at the facility. If the

staff member and/or the victim's parent, guardian or caregiver provides consent, the interviews may be audiotaped.

If MSDE or DJS need to conduct interviews separate from those conducted by DSS, a multi-disciplinary staffing that includes representatives of DJS, MSDE, and DSS shall be immediately held to share information and determine whether additional interviews of victims, staff or witnesses is appropriate or necessary. Regardless whether additional interviews are necessary all cases involving MSDE or DJS personnel shall be subject to a multi-disciplinary staffing within 30 days of the initial report to enable MSDE or DJS to take appropriate personnel action.

DJS shall assist in interviewing of victims and suspects and in the gathering of relevant information from the facility at the direction of DSS. This may include taking photographs of alleged victims and/or alleged perpetrators.

DJS shall ensure that victims receive appropriate medical and/or mental health treatment.

DSS and DJS may consult with SAO and MSP if they believe that criminal or juvenile delinquency charges may result, or should result, from any incident under investigation at the Charles H. Hickey, Jr. School.

IV. MULTI-DISCIPLINARY TEAM MEETINGS AND THE SHARING OF INFORMATION CONCERNING CHILD ABUSE AND CHILD NEGLECT INVESTIGATIONS.

Every investigation of child abuse and neglect at the Charles H. Hickey, Jr. School shall be reviewed at a Multi-Disciplinary Team meeting. The purpose of the Multi-Disciplinary Team meeting is to share information regarding the progress and/or results of the investigation.

All parties to this Agreement are standing members of the Multi-Disciplinary Team for child abuse and neglect investigations at the Charles H. Hickey, Jr. School. DSS, , MSP, DJS and MSDE staff with direct knowledge of an investigation shall attend the Multi-Disciplinary Team meeting for the investigation, unless such staff member is the alleged child abuser or child neglecter.

GOC shall receive a copy of the DSS investigative report at the conclusion of the DSS investigation. Under current practice, the DSS report is given to the Independent Juvenile Justice Monitor at the Multi-Disciplinary Team meeting and another copy is sent to the Director of the Office of the Independent Juvenile Justice Monitor at GOC.

V. FORMAL CHARGES AND PROSECUTION

SAO will have an Assistant State's Attorney available on an on-call basis for consultations on all cases involving child abuse at the Charles H. Hickey, Jr. School, which are being mutually investigated by MSP, and DSS.

Whenever possible, MSP or shall consult with SAO prior to arresting a suspect in connection with a child abuse or other criminal matter involving students at the Charles H. Hickey, Jr. School.

Upon arrest of a suspect in any child abuse case, MSP, and DSS may contact SAO and advise of any appropriate conditions of bail, which SAO should recommend to the judge conducting the bail review hearing for that suspect. SAO will make such recommendations concerning bail, provided such requests are timely and appropriate.

SAO shall maintain a separate unit known as the “Sexual Offense and Child Abuse Division” which will be responsible for the screening, formal charging, and assignment of all child abuse cases arising at the Charles H. Hickey, Jr. School. In addition, the SAO Division Chief will be available for consultation with MSP, and DSS regarding the decision as to whether to file formal charges in any child abuse case, which is being investigated.

DSS, and MSP shall make every reasonable effort to have investigative reports completed and forwarded to the SAO in a timely manner – within 60 days if possible. DSS, MSP, and DJS shall provide the SAO with a summary of the investigation at the conclusion of each respective agency’s investigation.

The SAO Division Chief or his/her designee shall present those cases involving child abuse, which have been scheduled for presentment before the Grand Jury. After formal charges have been filed in any child abuse case, the Division Chief will either keep the case himself/herself or specially assign the case to an experienced Assistant State’s Attorney who will be responsible for the handling of the case through disposition.

In order to spare the alleged victim additional trauma, the Assistant State’s Attorney will not interview an alleged victim of child abuse unless the case is reasonably certain to go to trial on the merits. In the event a child abuse case is reasonably certain to go to trial on the merits, the Assistant State’s can be present to assist during the interview of the alleged victim. DSS and MSP will be available to assist the Assistant State’s Attorney in any child abuse case with matters pertaining to the interview of the alleged victim, the marshaling of evidence and information regarding the results of investigations as well as the joint resolution of any problems regarding the location and transportation of the alleged victim to court for Attorney handling the case will notify DSS, when necessary, so that the appropriate social worker the trial of the case. DJS, as the agency with care or custody of the alleged victim at the time of the incident will assist in these activities at the direction of DSS, MSP and/or SAO.

VI. TRAINING PROGRAM

Each of the parties to this Agreement is committed to providing specialized training that relates to the field of child abuse and neglect, including, when possible, training that relates to institutional abuse and neglect. The respective parties shall insure that the other parties to this Agreement are aware of available training opportunities.

VII. APPEAL PROCESS

Each of the parties to this Agreement shall provide to the other agencies the resources required to support an agency personnel, abuse or neglect decision on appeal to the Office of Administrative Hearings, including making available necessary testimonial and documentary evidence in the control or custody of the party.

VIII. DATA REPORTING

The parties agree to share necessary statistical data on a quarterly basis. The DSS shall specifically provide to DJS statistical data on screened out cases on a quarterly basis.

APPENDIX F
Quarterly Report for April – June 2005

**MONITORS' ASSESSMENT OF FACILITIES AND THE
DEPARTMENT OF JUVENILE SERVICES RESPONSE
QUARTERLY REPORT, APRIL – JUNE 2005**

The **Allegany County Girls Group Home (ACGGH)** is operated by the Cumberland YMCA and located on property that is owned by the Maryland Department of Juvenile Services (DJS). The program serves nine female residents. Community resources for education, health and counseling are utilized, and ACGGH utilizes what it calls a “healthy home” model for treatment intervention and change.

The road leading to the facility continues to be in a state of disrepair and has been in bad condition for over two years. The Department of Juvenile Services has indicated that the road will be resurfaced in the fall of this year. Along with the surface repair, the trees lining the road should be removed so that the sun can dry out the surface after rain or snow. This will help provide for the longevity of the road.

Inside the group home, some repairs and improvements have been made. For example, the ceiling tiles in the basement have been replaced, a new dryer has been purchased, a new microwave installed, and new beds have been ordered.

Programmatically, ACGGH has geared up for summer. The residents have many and varied activities ranging including volunteering at the Rocky Gap Resort, participating in exercise programs and a church youth group, having cookouts, swimming and attending dances at the YMCA. Also, a trip to an amusement park has been arranged.

At times, routine and order seems to be somewhat lacking. For example, on several occasions the dorm and bedrooms have been unkempt and messy upon this Monitor’s visitation. This is an area that is being addressed in the training.

The program seems to continue to make improvements as staff are involved in training and teambuilding. Maintaining consistent structure from shift to shift, and helping staff improve positive effective interaction with residents are areas that continue to be discussed. Overall the staff seem to have positive relationships with the residents. Even when there is conflict, the residents express that they feel cared about by most of the staff.

Staff training led by psychologist Dr. Jim Miller occurs on a weekly basis. The Female Population Task Force monthly meeting led by Marian Daniel met on June 17, 2005 at ACGGH.

- **Unabated for 30 Days or More:** The property and grounds at the Allegany County Girls Group Home are generally kept in good shape, although the road leading to the facility continues to be in a state of disrepair. The Department of Juvenile Services has indicated that the road will be resurfaced in the fall of this year. Along with the surface repair, the trees lining the road should be removed so that the sun can dry out the surface after rain or snow. This will help provide for the longevity of the road.

Response:

The estimate for the road repairs is \$40,000. However, the Department of General Services ***did not*** select this site for repairs. It is not a priority for DGS. Therefore, the road will not be repaired until it is selected by DGS.

- ACGGH has become better known and recognized as a viable resource for referrals from the Department. As per diem funding diminished, fewer youth were referred to ACGGH and the program has accepted some DSS youth. Hopefully with new fiscal year funding available DJS will utilize better utilize this valuable resource for youth needing the services offered.

Response:

The department utilizes all available and appropriate resources. We assess all youth carefully to ensure that they are referred to the appropriate program.

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

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

The Youth Centers recently underwent a spring clean-up and beautification effort and contest. The youth had a poster and an essay contest, and each campus put a lot of effort into the beautification projects that included cleaning, painting, grounds work, and planting flowers and shrubs. There was a lot of pride demonstrated by both youth and staff. Meadow Mountain Youth Center won the contest, and as a reward, Cumberland DJS Youth Center Headquarter staff came to the Center and cooked and served a wonderful meal to the staff and youth of Meadow Mountain. This kind of creative effort has the potential to greatly enhance the sense of teamwork, pride, and ownership in the Centers and the treatment program.

One change in programming that will likely help enhance group process treatment in all of the Centers is that youths will now be enrolled directly into the Meadow Mountain Addictions Program. Candidates will be screened at intake at Green Ridge, and rather than going first to another Youth Center for orientation and behavioral adjustment, the youth will go directly to Meadow Mountain.

- Supervision on the second shift and on weekends has improved in the Youth Centers; however, this is still an area of concern. During the day, there is an abundance of staff including Residential Advisors, Case Managers, Administrative Staff and

teachers. While there is an attempt to maintain one staff per group plus one floating staff during the second shift, because of vacations, training, and call outs, this staffing level is sometimes not maintained. Case Managers are not always available in the evenings to run their group meetings or to run the EQUIP meetings. It is recommended that the Youth Centers reconfigure their staffing patterns to better cover second shift and weekends which are the most vulnerable times in programming, and to ensure that the youths' needs for treatment and supervision are best served, especially during evenings and weekends when the groups can plan off campus activities. Without sufficient staff, some of these activities have been cancelled. There has been more emphasis placed on teamwork in the Centers, and this needs to continue so that each group team functions as a harmonious unit in providing treatment. Teambuilding meetings should be held regularly to work out concerns as they arise, and to process the needs of youth in the group.

Response:

We will take the recommendations under advisement.

- Some groups in the Youth Centers still focus more exclusively on behavior, often missing treatment of the underlying dynamics that fuel the behavior, while other groups seem to develop more depth in the treatment process. In some groups the expectations for release are primarily about behavior, while in other groups more is expected of the youth in demonstrating an inward change. It is recommended that the process for recommending a youth for release from the Youth Centers be reviewed so that the maximum can be gained from the youth's residential treatment experience.

Response:

We will take the recommendations under advisement.

- While family involvement and aftercare planning has improved in the Youth Centers, this is still an area of programmatic weakness. Youth would benefit from enhanced and intensified family services, which might include the possibility of earning home visitation during the treatment program. In this way the transition back to the community could be facilitated gradually and incrementally. Longer visitations could be considered as progress in the program and in the community is demonstrated. Home visitations should also include intensive family support services.

Response:

We will take the recommendations under advisement.

- **Unabated for 30 Days or More:** The Youth Centers continue to operate without Commitment Care Standards and there has been no new initiative to reconvene the Commitment Care Standards Committee. There was a concerted effort in 2004 to develop Commitment Care Standards, including the involvement of the Office of the Independent Monitor; however, the Committee was disbanded in the fall of 2004 without completing its work. In the absence of official Commitment Care Standards,

a Procedural Manual developed by the youth Centers and Secretary Directives guides the Youth Centers.

Response:

No response necessary.

- **Unabated for 30 Days or More:** The filling of direct care positions at the Youth Centers has helped provide better supervision and services to families. An issue that impacts supervision, however, is the excessively long time that it takes for new staff to be certified to work alone with youth. This process often takes up to eight months, which is long after the new staff has received the required training to begin working with youth. Fingerprints are sometimes lost or unreadable, and the turnaround time for receiving criminal background checks is extremely slow.

Response:

Our Human Resources Unit has been working diligently to decrease some of the time frames currently being experienced. Beginning January 2006 the Department will have staff dedicated to providing information with a turn around time within 2-3 days. This new process has been designed to assist us in having completed certifications and approvals in a timely manner.

- **Unabated for 30 Days or More:** The Clinical Director's position or "Drug and Alcohol Addictions Counselor Lead" position at Meadow Mountain has been vacant for few years. An Addictions Counselor is functioning in an acting capacity and "wearing two hats" at this time. Full time staff are required to handle the responsibilities of each position, and the vacancy should be filled as soon as possible.

Response:

As soon as approvals are given and the process to fill the vacancies is completed, positions will be filled.

- **Unabated for 30 Days or More:** Recreational activities are a vital part of the treatment process, and should be provided for in the budget for the Youth Centers. However, this is not the case, and in the past the Centers have relied on the income from youth using the pay phones. In the contract with AT&T, 48 percent of the profit was returned to DJS. In the spring of 2004, however, this source of revenue was discontinued reportedly because the Department of Budget and Management approved a contract that provides a much lower commission on calls made from DJS facilities.

Response:

The budget department will be asked to review its decision on the changes that have been made.

- **Unabated for 30 Days or More:** As previously reported, an ongoing concern at the Youth Centers is the aging equipment, particularly the vans that are essential for transportation to clinic and other appointments, and for emergency use, especially in

the event of an evacuation. Breakdowns are much more common, and costly as the vans age. The Youth Centers have five vans: one 1999 Chevy with over 211,200 miles on it, and four 2001 GMC vans with approximately 141,600, 136,300, 144,500, and 120,800 miles respectively. The replacement of these vans will be a sizeable investment, and should begin incrementally as soon as possible.

Response:

This issue has been responded to repeatedly. The Department does not determine when or if vehicles will be scheduled for replacement. DGS does not respond to request for replacements they follow a schedule.

The **Young Women's Facility of Maryland at Waxter** is a State-owned and operated detention/residential treatment facility located in Laurel, Maryland that operates under DJS Detention Standards and other DJS policies and procedures. The facility houses females under the age of 18 and has been comprised of one detention unit and three programming units. Due to physical plant limitations and programming concerns, two of the programming units - substance abuse treatment and short-term commitment - were gradually downsized and eventually terminated in May 2005. The program now consists of detention and long term commitment care. For those youth requiring substance abuse treatment and/or short-term commitment care, DJS plans to purchase services in community settings. However, due to DJS's budget crisis, adequate funding to support the purchase of services is not likely to be available to meet the need of all youth. In fact, the number of youth in detention in pending placement status continues to increase, a reflection of the difficulty in securing purchase of services. While this facility's population has been reduced (43 on June 16th), the pending placement population now represents approximately half of all youth in detention.

This monitor conducted several unannounced visits according to the operating procedures for this office. The current superintendent, ms. Janice gardener, began in January 2005, continues to review existing facility policy and procedure and establishes new protocols to refine the facility's operation.

- Ms. Shelly Mintz, the Assistant Attorney General assigned to DJS, has been instrumental in establishing meetings with various local departments of social services (DSS) in jurisdictions where DJS facilities are located in order to follow up with developing a written protocol between DJS, Child Protective Services, the State Police and the State Attorney's Office for responding to and handling abuse, assault, and other violent incidents. A meeting was held on June 14, 2005 at the Anne Arundel County Department of Social Services regarding this matter. The agreement developed in Baltimore County with regard to the Hickey School was reviewed and discussed with possible amendments to address the needs at Waxter. At least one follow up meeting will be required prior to the ratification of an agreement in Anne Arundel County. Ms. Mintz's initiative on this matter is commendable.

Response:

Ms. Mintz and the department appreciate your recognition of her efforts.

- **Unabated for 30 Days or More:** A review of the ICAU Incident Report Database for April through mid-June 2005 revealed that assaults/use of force incidents remained relatively constant at an average of 0.8 per day as compared to the same reporting period in 2004. Measures to reduce the level of assaultive behavior and the use of force are necessary. Continued focus upon program enhancement may be of benefit.

Response:

We are continuing our focus on developing program enhancements as well as intensive training for the staff. We have implemented an After-School Recreation Program and Canteen Program. All of these areas combined should assist in reducing the level of assaults.

- **Unabated for 30 Days or More:** With regard to the use of seclusion, the documentation and use of seclusion still does not appear to be in strict compliance with current policy and procedure. It is recommended that Waxter implement procedures addressed in the recent department-wide training and that staff review the corrective plan submitted by BCJJC.

Response:

We will direct staff to follow the Seclusion Policy as it is written and they will be held accountable for lack of follow through.

- The suicide watch logbooks must contain accurate documentation.

Response:

We have revised the process for documentation of the suicide watch logbooks. Managers will be responsible for meeting with staff and reviewing the process with them.

- **Unabated for 30 Days or More:** Youth are being detained on pending placement for too long. On June 16, 2005, there were 17 pending placement youth. DJS must be given sufficient fiscal resources in order to expedite the placement of these youth not only in this facility but all detention facilities in Maryland. These youth are entitled to individualized treatment services that DJS can not provided in a detention environment.

Response:

We recognize the need to move youth as quickly as possible to the appropriate placement. While we are not making excuses, this is not always possible. We will continue to be diligent in placing youth in the most appropriate program as quickly as possible.

The **Baltimore City Juvenile Justice Center (BCJJC)** has the capacity to house 144 male detention youth but concerns with access to the second tier handrails decreases the number of beds legitimately available. The property is owned and operated by DJS and is governed by the Maryland Department of Juvenile Services Standards for Juvenile Detention Facilities.

- **Unabated for 30 Days or More:** Youth on youth assaults and use of force incidents have continued to increase dramatically – with April posting an all time high of 100 assault/use of force incidents. Many reports listed as “other” in the ICAU database also appear to be use of force or other aggressive-type incidents. On June 18, 2005, there was a major group disturbance that resulted in significant property damage, injuries to youth and staff, and the improper use of seclusion. Baltimore City Police responded to the facility and had to mace and flexcuff numerous youth to regain control. There was confusion and disorder when units were mixing in the open pod area as youth from one unit were receiving haircuts while another unit was being moved for recreation. Staff must keep the facility under strict order and control. Youth from different units should not be permitted to interact and mix while engaged in separate activities unless heavily supervised.

Response:

New procedures are in place to ensure that the movement of youth will not create confusion and disorder. Groups will only interact with each other during education, recreation and mealtime. All movement will be conducted one at a time with units not mixing in the hallways. All doors will remain secured at all times.

- **Unabated for 30 Days or More:** There is still no written interagency protocol between the Maryland State Police, Baltimore City Police, the Department of Social Services and the Department of Juvenile Services to respond to incidents of child abuse and/or neglect and other major incidents.

Response:

Ms. Mintz is working on interagency agreements for all of the state operated facilities. In the meantime, we have an unwritten agreement between the Maryland State Police and the Department of Social Services to respond to incidents of child abuse and neglect and other incidents. In addition, the Maryland State Police have assigned an officer to the facility to provide the needed oversight and response.

- **Unabated for 30 days or more:** Staff are still working forced overtime. Logbook reviews and staff interviews reveal that some shifts have only one staff person working on a unit at a time and some very inexperienced staff are left alone and held responsible for youth.

Response:

The department will begin to hire staff from Hickey who have been certified and have experience in working with this population. This will assist in the reduction of overtime and the use of inexperienced staff. Also staff from Cheltenham will be temporarily assigned to the center.

- **Unabated for 30 Days or More:** Seclusion is still not being recorded and it appears that it is still being used for punishment. Youth should not be held in

seclusion any longer than necessary and only as long as they are an imminent threat to the safety of staff or others. They must be processed out as soon as possible.

Response:

Youth will be assessed per policy to determine whether or not the continued use of seclusion is warranted. Processing with youth will continue throughout the youth's stay in seclusion and efforts will be made to have the youth released from seclusion as soon as possible. In addition, a new Seclusion protocol is being developed.

- **Unabated for 30 days or more:** Programming and education are still insufficient. Youth do not always receive the required number of hours for education and they often refuse to attend school because they know they will not receive any credit for their classes when they return to their home school. In addition, some youth are not receiving the proper exercise. It has been reported that large muscle activity sometimes consists of playing an x-box computer game.

Response:

The 24-hour schedule has been revised for the facility to ensure that youth receive 5 hours of education. Teachers now work a staggered work schedule to accomplish this task. The X- box is used during leisure activities not as a large muscle activity.

- Reviews of case records reveal that treatment plans are not being developed by staff to address the individual needs of the youth. Case management staff claim they do not have sufficient access to computers to update youth records.

Response:

The treatment plan process has been revised and implemented by behavioral health staff.

- **Unabated for 30 days or more:** Master control still needs to be more orderly, organized and under control. When master control staff attempt to get a count of the number of youth, they often yell over the radio to get a response. During one observation period, it took longer than 20 minutes to get an accurate count of youth.

Response:

Master control and floor control have been designated as a highly restricted area. The supervisor over the control rooms will ensure that the area is kept neat and orderly.

- **Unabated for 30 days or more:** Door locks do not always engage when doors close and should be maintained so they secure properly.

Response:

Daily inspections of the locks will be conducted by direct care staff to ensure they are operating properly. Weekly inspections will be conducted by administration. Maintenance will immediately repair any locks that are brought to their attention as being inoperable.

- **Unabated for 30 days or more:** The dining hall serving line still does not have a barrier erected to prevent youth from jumping over the counter and entering the kitchen.

Response:

The request for a barrier has been submitted to headquarters and capital planning for this modification to be performed. Youth are directly supervised in the dining hall by staff to ensure that no one climbs over the counter.

- **Unabated for 30 days or more:** Youth still have access to the second tier handrails on the living units, which might result in a hanging suicide. DJS has previously advised that the second tier would be closed and even after repeated warnings, several youth attempted to hang themselves from the railings in April and May. A recent remedy was to not allow youth on the second tier unaccompanied by staff; however, youth were observed on the second tier unaccompanied by staff. A youth was also observed climbing over and through the second tier rail and dropping onto the steps below.

Response:

The Department has received three estimates to install guard and handrails on the second tier of the pods. The estimated costs are: \$279, 850, \$571, 920 and \$436,950. No decision has been made on when the repairs will take place.

A directive has also been given to all staff to not allow youth on the second tier unescorted.

- This monitor was a member of the Juvenile Detention Alternatives Initiative (JDAI) steering committee that resulted in inspection tours of the facility in April. However, this office may not have access to the results of the inspections because they will reportedly be used for internal purposes only.

Response:

No response necessary.

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

- **Unabated for 30 Days or More:** Staffing at the facility is insufficient. There are 12 youth on each unit and normally only one staff supervises each unit. There should be 2 staff on every unit to respond to situations that require immediate

attention. Staffing at the facility remains insufficient to implement appropriate programming and recreation while maintaining security/safety. Facility personnel are researching opportunities to gain more money, resources and staff and DJS headquarters should work with facility administrators to explore grants and or other federal monies available to help supplement, hire and/or train staff.

Response:

Staff are being recruited to fill the vacant positions. Interviews were completed July 19, 2005 for two Resident Advisor positions. Request to fill the remaining vacancies have been submitted for approval.

- **Unabated for 30 Days or More:** There is still a concern that some inappropriate youth are placed at the facility. Aggressive youth with a chronic history disturbing the culture at the facility are returning. DJS should work with the judicial community to better communicate the facility's appropriateness for youth needing placement.

Response:

Youth who are ineligible for Detention or return to their home will continue to be placed at the Shelter Care facility. This is not an arbitrary decision. This is based on an appropriate assessment of the youth using an instrument that determines appropriate placement.

- **Unabated for 30 Days or More:** There is still confusion about identifying the facility as a "shelter" or as a "staff secure facility." Since MYRC is designated as a shelter, youth should not be labeled as "escaping" (from a staff secure facility), but should be labeled AWOL. The importance of this designation determines if a youth may or may not be "restrained" for attempting to escape and whether the youth can be charged with "escape."

According to the DJS description of MYRC, " In June 1994, it was converted to a shelter care facility...." Shelter Care is identified by DJS in the Common Terms section of their website as "24-hour care for youth in physically unrestraining facilities" whereas Structured Shelter Care is identified by DJS as serving "youth who have been removed or displaced from their homes and families and are in need of short term care for up to 90 days."

DJS defines structured shelter in their Program Types under the Residential Services section of their website as: "State operated and vendor operated facilities that provide residential care, usually less than 30 days, in a staff secure environment for youth who are either runaways or are awaiting a court hearing or residential placement." Although the term "staff secure" is in one of the DJS definitions of a shelter care facility and staff secure is identified by DJS as a program "where a youth's movement is controlled by staff supervision rather than by restrictive architectural features", COMAR does not identify any facility as "staff secure." Definitions relate to "Secure Care" or Shelter Care." Secure care

programs employ locked doors to prevent escape while shelter care programs are not locked. DJS should clarify these discrepancies in facility identification.

Response:

Staff will be trained and or reminded to use the appropriate language in the incident reports to reflect AWOL instead of escape. Youth who leave the facility are being labeled as AWOL instead of escape.

- **Unabated for 30 Days or More:** Maintenance issues continue to exist surrounding the south side bathroom and dining areas of the facility. Recent repairs to the walls and ceilings were merely cosmetic and have not eliminated the water leak problem. This Office continues to recommend that repairs be made to permanently stop the leaks that cause damage to interior ceilings and walls.

Response:

The Department of General Services (DGS) has hired an architect to develop the plans to renovate and repair all of the outstanding issues. The costs have not yet been determined. Once the estimates are received, **DGS** will make the **final** decision on the repairs based on available funding and their priority list.

- **Unabated for 30 Days or More:** The facility is still in need of an additional transportation van. Youth are missing the opportunity to attend important off-campus activities and this Office continues to recommend that the facility obtain another transportation van

Response:

This issue has been addressed numerous times in the IM reports. The department does not have the authority to replace vehicles. This is a decision made by the Department of General Services based on their vehicle replacement schedule.

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.

- Overall, the facility maintains a very clean interior and exterior; however some tiles near the tub in the third floor bathroom are missing or damaged. Currently, the youth must step onto a piece of wood when stepping out of the shower.

Response:

The tiles were repaired/replaced during the week of May 12, 2005.

William Donald Schaefer House accommodates 19 youth, and provides a three-month substance abuse recovery program. The program consists of individual and group counseling, education, and additional off and on grounds activities that contribute to the overall program. Many of the community activities provided by the program offer opportunities for youth to enhance their self-esteem by making a contribution to others. Overall, effective treatment, and educational services are provided at Schaefer House for youth that choose to actively engage in the program. Recently it was reported that eight of eight GED candidates passed the exam, and earned their diplomas. Indications are that most of the youth who successfully complete the treatment program do not re-offend.

Recently the program has experienced some acts of violence on the part of a few residents. Also, a couple of youth have gone AWOL from the facility. The outbreak of aggression and AWOL is unusual, and reportedly, worse than it has been in the twelve-year history of Schaefer House. The program is designed to help youth who are experiencing problems with addictions. It is not intended to treat youth with histories of violent or severely aggressive behavior.

The facility, described as once beautiful, is in a state of neglect and disrepair. In addition to repairs and cleaning, new furniture is needed especially in the youth bedrooms. The physical plant problems at Schaefer House are numerous. The total expense to upgrade the home will likely be significant. The Department of Juvenile Services is understaffed with maintenance personnel, and short of funding necessary to complete the overall needed renovation of the facility. Many of the cosmetic and simple repairs and upkeep, however could be made quickly and, it would appear, relatively inexpensively.

One of the most urgent concerns, the hole in the roof, has been repaired. Some of the other repairs that have been completed include: covering the sockets in the bedrooms, repairing the hanging smoke detector in bedroom #10, fixing the lock in bedroom #11, removing the overflowing urinal from the 2nd floor bathroom to unclog and return, placing a cover over the socket above the sink in the 2nd floor bathroom, fixing the exit light on the 2nd floor hallway, fixing the leak in the sink in the 2nd floor utility closet, fixing the telephone jack in the staff area, and fixing the sockets over the sinks in the 3rd floor bathroom. The gutters have been replaced where they were leaking, and as mentioned above, the hole in the roof has been repaired.

- Admissions at Schaefer House have included some youth with a history of violence whose needs exceed the capacity of the program to provide safety, security, and treatment. At times, referral information is incomplete and/or not up to date.

Response:

All youth are carefully screened for programs to meet their needs. Sometimes youth display behavior that may not be obvious in the screening process. When referral information is incomplete, the case manager will seek the additional information from the appropriate persons.

Unabated for 30 Days or More:

- **Kitchen:**
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.

Response:

We will be contracting with a cleaning company to complete a power cleaning in the areas that are in need. The maintenance issues will be completed by the maintenance department.

- **Kitchen Storage Room:**
The ceiling has not been repaired.
The hole in the wall beside the door has not been repaired.

Response:

Both the ceiling and the wall beside the door have been repaired as of this writing.

- **Sunroom:**
Caulking is needed to prevent outside air from coming into the room.
The ceiling vent covers should be replaced.
The furniture is very old and should be replaced.

Response:

Furniture has been ordered. Because we order through SUI, the furniture will not be delivered immediately.

- **Bedrooms:**
The dressers are in disrepair and should be replaced.
Many of the blinds are damaged and should be replaced.

Response:

Furniture and blinds have been ordered and are being replaced as they become available.

- **2nd floor bathroom:** There are two showers; however, maintenance workers removed the shower handles approximately one year ago but never replaced them. This leaves only one working shower on the 2nd floor. The tile in the showers is covered in mildew and some tiles are missing.

Response:

DGS has hired an architect to develop a plan to construct new bathrooms. Once the plan is completed, construction will begin based on the availability of funding.

- 3rd floor bathroom: The fixture in one of the showers will not turn off properly. The staff and youth have to twist it up and down then pull it in and out before the water will stop.

Response:

DGS has hired an architect to develop a plan to construct new bathrooms. Once the plan is completed, construction will begin based on the availability of funding.

- Laundry Room: There is only one working washer and one working dryer for the 19 youth. Both are old and inadequate to meet the laundry needs.

Response:

We have ordered a heavy washer and dryer for the facility. They will be delivered as soon as the vendor can schedule the delivery.

- Boiler Room: The door to the circuit breaker box will not close and should be repaired. The screens and window casings have rotted, allowing leaves, dirt, rodents, etc. to enter through the windows.

Response:

The circuit breaker box has been repaired.

- Recreation Room: This area is filled with mold and mildew on the walls, windows, exposed pipes, and ceiling. The gym mats are covered in dust and dirt. There is no outside ventilation for this area because the windows remain closed. The weight equipment is old and may not be safe for use. The ping-pong table is not used, and the foosball table is uneven and propped up with weights.

Response:

This response is addressing all of the maintenance concerns listed above. The Department of General Services has hired an architect to develop a plan and time line for construction. The repairs will be completed based on the availability of funds.

DGS did approve four projects for critical maintenance that is included in the FY06 budget. The cost is \$75,000 for buildings 907 and 909. As soon as the time line is made available, the monitor will be informed.

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

- The average length of stay was 10 days and the average population was eight youth.
- This Monitor reviewed four resident files and found that none had an updated individualized service plan (ISP).

Response:

All files have been corrected and will be monitored for compliance.

- **Unabated for 30 Days or More:** The facility continues to have many physical plant issues that were cited in previous monitoring reports.

Response:

The Department's Maintenance Chief has been directed to inspect the cited issues and assess the repair needs.

The **Charles H. Hickey School** is the Department of Juvenile Services' largest facility and has increased its population to more than 200 youth at times. The facility is comprised of detention units, and programming units designed for 30 days to 18 months programs.

- **Unabated for 30 Days or More:** Population at the facility rose from 185 last quarter to over 200 this quarter and assault/use of force incidents per day increased from an average of 1.9 per day to 2.5 per day (April and May). Youth on staff assaults have risen from an average of 7 per month last quarter to 10 per month this quarter (through June 18). These incidents of assault and use of force must be reduced.

Response:

The increase in incidents can be associated with the number of volatile youth in residence here during that time period. It should also be noted that many involved fights between youth and, the aggressor was referred to the State Police for possible criminal charges. This is in keeping with the Department's mandate to report all incidents, in accordance with the Incident Reporting Policy. We are reluctant to infer that particular employees are abusing youth. Whenever, there is an allegation, it is immediately reported and the Department of Social Services and OPRA for investigation. If there is a finding that an employee is abusive to youth, they are either discharged or other appropriate disciplinary action is taken.

The population has been decreased and will decrease more as programs close and the department prepares the closing of parts of the facility.

- There are still concerns with investigators from DJS, MSP and DSS not fully coordinating their child abuse investigations according to accepted practices. Victim youth are being unnecessarily interviewed numerous times. Also, MSP

and Hickey representatives are sometimes either not attending or are not prepared for multi-disciplinary meetings. One of the most helpful guides to investigating child abuse can be found at <http://www.ncjrs.org/txtfiles/162425.txt>. This portable guide was developed by the National Criminal Justice Reference Service in 1997 and updated in 2001.

The Office of Juvenile Justice and Delinquency Prevention has also published an outstanding protocol for responding to incidents of child abuse that can be found at <http://www.ojp.usdoj.gov/ovc/publications/factshts/monograph.htm>.

Response:

In regards to the Hickey representative not being prepared, sometimes a last minute replacement has to be sent if there are pressing issues for the regular representative at the facility. However, the standard protocols for the meetings do not require a lot of preparation by anyone other than the DSS investigator. These meetings are held after the investigations have been completed, and a decision has been rendered in regards to a finding of Child Abuse or Neglect. Usually, the Hickey representative is asked about the action taken in regards to the findings and sometimes asked if the child is still in residence.

- There were 17 incidents of suicide ideation, gestures, behavior and attempts during last quarter and that has risen slightly to 20 through June 11 of this quarter. Improving the conditions of confinement, programming and treatment may reduce suicide attempts, gestures, ideations and behaviors.

Response:

We do agree that as the conditions of confinement improve and the number of youth decrease, we will see a reduction in the number of suicide attempts, gestures, ideation and behaviors.

- **Unabated for 30 Days or More:** Seclusion is still being used inappropriately as a place for youth who are acting out in school. Administrators should work with education personnel to develop a “time-out room” for youth exhibiting poor behavior in the classroom, instead of sending youth to seclusion. Seclusion procedures must be followed and youth who are not an immediate danger or threat should be processed back into the population as soon as possible

Response:

Administration at Hickey and the school agreed upon the "time-out room" concept in the school. Youth are removed from the classroom and placed in another room with his class work and supervised by a Hickey employee, until he is ready to return to the regular classroom. If his behavior continues to escalate and he becomes a danger to himself or others, he may be removed to seclusion. Our practice is to return the youth to school as soon as possible. This has been worked out with the school administration.

- **Unabated for 30 Days or More:** A sufficient number of fulltime staff must be hired and maintained to decrease the amount of overtime being worked by personnel who are becoming tired and overworked.

Response:

With the closing of many of the units on November 30, 2005, additional staff may become available for the remaining units. With the unit closings, additional programs will be developed for the remaining units.

- **Unabated for 30 Days or More:** There are still concerns about vocational and weekend programming, and the lack of sports programs that might provide incentives for good behavior. Vocational programming, after school/weekend programming and athletic participation should be increased.

Response:

Vocational programming falls under the auspices of the Maryland State Department of Education. They currently have programming that involve youth in learning electrical wiring, drywall installation and building maintenance.

The facility now has two (2) Recreation Specialists and the programming has increased. We will continue to recruit for vacant positions.

- **Unabated for 30 Days or More:** Illegal contraband and suspected illegal substances that are recovered at the facility should be processed according to established procedures and evidence should not be improperly handled.

Response:

We will request that OPRA provide training to the Shift Commanders in the proper handling of illegal substances and they will be responsible for seeing that all staff are trained in the process.

- **Unabated for 30 Days or More:** The pedestrian sally port gate was observed not functioning, door locks are still a concern and toilets were observed leaking. The pedestrian sally port gates should be maintained and working properly to prevent a security breach. Toilets should be repaired when they are discovered leaking and DJS should consult with professionals to determine the best door lock available for existing doors in detention or consider upgrading the doorway structure and changing the bedroom doors in detention to solid steel.

Response:

Because the sally port was repaired, a visit with the monitor will be scheduled to determine the repair needs that the monitor has observed. Other repair requests have been submitted to the Maintenance Department.

- **Unabated for 30 Days or More:** The parking lot at the entrance to the facility still needs to be expanded. The roadway adjacent to the parking lot is still often crowded with vehicles that both block the safe entrance into the facility, and cause hazardous ruts and holes in the dirt alongside the roadway.

Response:

We have been aware for sometimes that there is a need for additional parking. We have been successful in keeping the main road clear of vehicles, but it creates an additional hardship for employees. During the week of August 1, 2005, a contractor began work on creating about 8 additional parking spaces adjacent to the existing parking lot. We will continue to plan for this area, and factor in the closing of six (6) cottages and reducing the number of employees by approximately 50.

The Department of General Services has approved limited paving for the eroded areas across from the sally port. The parking lot will not be expanded as requested by the monitor.

- **Unabated for 30 Days or More:** Even after repeated citing by this Office, the ceiling vents on the bedroom units are not suicide-proof.

Response:

An engineer has been hired to develop a drawings and specification for suicide resistant vents_or replacement vents. Upon additional investigation of the suicide resistant vents, it has been determined that installation of the vents could interfere with the HVAC system.

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

Response:

The funding for the cameras was cut by the Legislators. Consequently, we were awaiting funding for the replacements cameras. With the decision to close the facility, it is unlikely that cameras will be installed.

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

- **Unabated for 30 Days or More:** Although some flowers were planted in the front of the building, maintenance issues continue to exist surrounding the daily upkeep and appearance of the off-grounds Transitional Living Continuum. The Center, , DJS, and Springfield State Hospital must find ways to enhance the appearance of the TLC buildings and grounds

Response:

Contact has been made with administrators at Springfield State Hospital and they have been responsive to our requests to provide maintenance for the building and grounds.

- **Unabated for 30 Days or More:** Although DJS has assured there would be a written agreement enacted, and although the police and DJS have cooperated to remove a violent youth from the facility in one recent case, there are still no written interagency agreements for incidents of assault, escape and abuse.

Response:

At this point, the monitor will have to be patient as the agreements are being developed with all of the facilities. As stated in the past, there will be an agreement developed.

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

This facility continues to provide outstanding services to the females who are appropriately placed in its program. Teachers at the facility have expressed an interest in obtaining past education history from youth through the DJS ASSIST system so they can develop more effective and focused programs for youth.

Response:

We have investigated options for providing this request and feel that youth who are new to the system the information will not be in ASSIST and for those youth who have a history with the Department, the case manager should be able to provide the educational information...

- It appears some youth are still being inappropriately referred or placed at the facility. Several placements of youth in April were inappropriate. Also, several AWOL incidents and a fight in June were due to the actions of a particular youth who was apparently inappropriately placed at the facility. DJS should ensure youth are appropriate for placement at the facility.

Response:

Youth who cannot be detained and who are in need of out of home short-term care are appropriately placed in shelters. All youth are assessed using a Risk Assessment Instrument that determines the level of placement. Placements are not made arbitrarily.

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

- The facility now has a full time Acting Superintendent.

- The facility's population ranged from approximately 15 through 25 during the reporting period.
- The staff continues to be overworked due to a staffing shortage. The facility operates with seven staff to fill the weekly schedule.

Response:

We continue to recruit and hire staff for the vacant positions.

- There was one group disturbance involving five female youth that required law enforcement officers to assist staff. No one was injured during the incident. The facility no longer houses females and all Eastern Shore females are housed in the Lower Eastern Shore Children's Center.
- On May 17th, two male youth escaped through an unlocked back door and climbed over the facility's fence when a staff member failed to lock the door after the evening outside recreation period. The fence did not have a security "mesh" type material over it that would prevent youth from climbing over. Maintenance staff did not repair the fence for approximately three weeks, even though the youth and staff continued to go outside everyday.

Response:

All of the needed repairs have been made to the fence. It would have been inappropriate to deny youth their recreation time since the youth who AWOLed did not leave the facility during the recreation period.

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

Response:

No response needed.

- The interior of the facility was painted and cleaned. Other upgrades should be made to improve the facility's appearance.

Response:

Recommendation noted.

- **Unabated for 30 Days or More:** In a previous report, this Monitor cited two wooden doors leading to the intake area and sleeping area that were damaged by a youth who applied too much pressure to the handles. The doors still have not been replaced with a more secure fixture designed for detention facilities.

Response:

This issue has been referred to the Department of General and they have not responded.

The **Alfred D. Noyes Children's Center** (Noyes) is a State-owned and operated detention facility that houses both males and females under the age of 18. The facility operates under DJS Detention Standards and other DJS policies and procedures. During the previous reporting period, this Office issued a Special Timely Report documenting a number of child abuse allegations at the Noyes. Montgomery County Child Protective Services issued findings of involvement by at least two staff and the Department of Juvenile Services substantiated violations of Department policy and procedure against a number of staff.

An acting facility administrator, Mr. Carlton Richardson, was appointed to oversee the operation of this facility in March 2005. Mr. Richardson has initiated numerous positive changes since his appointment, however, the facility still lacks a full compliment of staff to provide ongoing supervision of the youth. Accordingly, the facility experienced a number of significant events during this reporting period including a successful escape and a near escape. The Department continues with the recruitment of staff to fill the current vacancies.

- A new Behavior Management Point/Level System Program has been implemented.

Response:

No response required.

- Mr. Richardson has put into place a more activity based daily schedule. According to Mr. Richardson, an anger management group, hygiene group, clinical services group lead by the facility's psychologist, and conflict resolution group have all been initiated one time per week for each unit. Also, plans to have case managers from field services lead a group in the facility are being explored. Further, grant funding will be available on July 1st from Montgomery County to have a psychiatrist available for approximately 32 hours weekly.

Response:

No response required.

- In April, the educational department invited parents and guests to a performance by the youth, "A Stroll Down Memory Lane", in which youth and staff offered a bibliography and selected musical numbers by Ray Charles, the Temptations, and the Five Heartbeats. Afterwards, refreshments were offered to the youth and parents while staff briefed the parents on the programming and counseling sessions offered by the facility.

Response:

No response needed.

- Other special activities included a presentation by Class Acts Arts/Project Youth ArtReach. On May 5th, parents were invited to the facility to celebrate “Embracing Cinco De Mayo” with native food sampling, music, and dance. On May 20th, the facility sponsored a “Stakeholders Day”, an open house for DJS field staff, judges, and others.

Response:

No response needed.

- Radios for staff arrived in late May. The radios have enhanced staff communication, especially when youth are present in the school trailers outside the primary building, and improved security.

Response:

No response needed.

- **Unabated for 30 Days or More:** Until the vacant direct care staff positions are filled, it is critical that more than one staff be placed on a unit to provide the required level of supervision and to ensure the protection of residents. Without this additional coverage, the ratio will continue to be one staff for approximately 15-20 youth, which far exceeds national standards, best practices, and DJS’s articulated goal of a 1 to 8 ratio. During the quarterly visits by this Monitor, the facility’s population ranged from 47 to 60 youth. On May 25th (total population 57), the three male units had 19, 16, and 13 youth each. The female unit had 9 youth. The use of transportation personnel may be an available resource on a temporary basis.

Response:

Thanks for the suggestion to use transportation personnel. We have always used the transportation staff for escorting, searches and supervision of youth, which augment coverage. The daily population has also been reduced. In addition, staff have been reassigned for different facilities.

- **Unabated for 30 Days or More:** On May 25th, there were 23 pending placement youth and 34 pre-dispositional secure detention youth. On June 15th, there were 21 pending placement youth and 28 pre-dispositional secure detention youth. Of the 23 pending placement youth on May 25th, four had lengths of stay in pending placement status exceeding 30 days - 66, 38, 33, and 30, respectively. DJS must be given sufficient fiscal resources in order to expedite the placement of these youth not only in this facility but all detention facilities within Maryland. These youth are entitled to individualized treatment services that DJS can not provided in a detention environment.

Response:

Facility case managers are engaged in aggressive case management practices to expedite the placement of the pending placement youth.

- **Unabated for 30 Days or More:** A review of the ICAU Incident Report Database for April through mid June 2005 shows that assaults/use of force incidents remained relatively constant with the cumulative number remaining the same as during the preceding quarter. The quarterly average of assaults/use of force incidents averaged .6 per day. Immediate measures are required to reduce this level of serious incidents. Increased staff should assist.

Response:

Immediate measures have been taken to reduce the assaults and use of force. Additional staff have been hired and additional activities have been programmed for the youth.

- On April 13, 2005, a staff member was accused of grabbing a youth's arm. State police were called and responded promptly to the facility. Child Protective Services was also called. While no criminal charges were filed and OPRA did not substantiate any misconduct by the staff, the staff person was not placed in non-contact status with youth during the pending investigations contrary to existing DJS policy. DJS policy must be consistently followed.

Response:

Administrative staff will ensure that DJS policies and procedures are consistently followed by all staff.

- Ms. Shelly Mintz, the Assistant Attorney General assigned to DJS, has been instrumental in establishing meetings with various local department of social services in jurisdictions where DJS facilities are located in order to follow up with developing written protocol between DJS, Child Protective Services, the appropriate law enforcement agency and the State Attorney's Office for responding to and handling abuse, assault, and other violent incidents. Two meetings were held on at the Montgomery County Department of Social Services on this matter. The agreement developed in Baltimore County with regard to the Hickey School was reviewed and discussed with possible amendments to address the needs at Noyes. Ms. Mintz's initiative on this matter is commendable.

Response:

Thanks for recognizing our efforts to develop protocols with the agencies.

- A youth gained access to an unsecured fire extinguisher in the educational trailer and succeeded in discharging it at staff. This Monitor had previously identified the access of the fire extinguishers as being problematic, as well as the toilet tank tops and toilet seats in the trailers that can be used as weapons. These security liabilities require remedy.

Response:

Continue administrative and managerial review of logbooks. Conduct documentation trainings.

We will issue documentation instructions to staff during unit team meetings.

- **Unabated for 30 Days or More:** The logbooks contained more detail than noted in the previous quarter's report, but entries are still not consistently entered in a manner to sufficiently detail all significant activities and note regular supervisory presence on the unit. Continued supervisory attention and review of logbooks must take place to ensure the appropriate recording of events.

Response:

The administrative staff will continue administrative and managerial review of logbooks. In addition, we will conduct documentation trainings for the Resident Advisors. Documentation instructions will also be presented to staff during unit team meetings.

- **Unabated for 30 Days or More:** The residents still complained that ants and other insects are present on the units and in their rooms. This Monitor also observed the presence of the insects on the units. Previous actions to address this issue have not been successful. Additional attention to this issue is required.

Response:

We have purchased a different insecticide and we have completed several comprehensive sprayings of the infested areas.

- **Unabated for 30 Days or More:** Youth are receiving more outside recreation than previously noted. However, it is still not a daily activity as required. Additional attention and commitment to this matter to ensure that it becomes a daily event.

Response:

The administrative staff have continued to instruct staff to utilize the outside recreational area for the heavy muscle activity period recorded on the unit's daily schedule.

Management will ensure the completion of Activity Roster to record outside recreation and special activities

We have also submitted the appropriate paperwork to hire two recreational staff

- **Unabated for 30 Days or More:** The hiring of specialized staff to administer the recreation program is also required. This position should help ensure that the appropriate recreation schedule is maintained.

Response:

Two recreation staff have been hired.

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

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

- The total population during this reporting period ranged from approximately 70 to 100 youth.
- The number of youth on youth physical altercations has remained steady during this reporting period and there was one youth on staff assault.

Response:

No response required.

- The administration continues to reduce the use of seclusion.
- On May 6th, a youth escaped from the Alfred D. Noyes Children’s Center in Rockville. Approximately two weeks later, this Monitor found the youth being detained in CYF, however, DJS was not aware that the youth was in custody. The CYF admissions staff failed to properly search the ASSIST database for information on the youth.

Response:

This was an isolated incident that has been addressed. Management has met with the Facility’s Intake and Social Services staff and reiterated that a thorough search of ASSIST must be conducted on each youth entering the facility.

- Many of the staff radios are old and damaged causing interference during transmissions.

Response:

This has been corrected.

- The facility had its first “Open House” in May for DJS community services staff to attend a tour and cookout. The youth, facility staff, and community case managers shared lunch together while the youth were available to address questions.
- **Unabated for 30 Days or More:** The facility continues to operate with one mental health professional. A contractual psychiatrist prescribes the youth’s mental health medication and monitors the effectiveness. However, only one mental health associate is responsible for providing mental health services to the youth on a daily basis as well as being on call for emergencies.

Response:

An agreement has been reached with the Prince George’s County Mental Health Department to provide staff to service the mental health needs of the youth assigned to the facility.

The **Western Maryland Children's Center (WMCC)**, located in Hagerstown, is designed to accommodate up to twenty-four youth. Despite staff shortages and being forced to take in other area youth, the staff at WMCC continued to put forth a lot of effort in maintaining a positive atmosphere. Youth Center staff have volunteered to help out at WMCC, and this has been a great help. At times WMCC has been asked to take disruptive youth from other detention facilities, and recently, WMCC received a youth from Baltimore City Juvenile Justice Center on an emergency basis. Upon intake, the youth revealed that he had tied a sheet around his neck at BCJJC in a suicide gesture. This information was not forthcoming from BCJCC, or from transportation, and could have resulted in a tragedy. This kind of lack of communication is very dangerous to youth to staff, and is a potential liability for DJS.

The greatest challenge to maintaining the programming at WMCC is staffing. Staff shortages, forced overtime, long commutes for staff hired from Allegany County, and stronger staff having to cover for less capable staff are all issues that affect morale and programming. Recently WMCC was given permission to fill staff vacancies and has conducted a number of interviews. This will help WMCC, though it is a lengthy process of many months from the time a new hire is offered a position until the employee is certified to be alone with youth.

Other than this critical issue of staffing, elements of the facility itself continue to present a safety concern. The physical plant of the Western Maryland facility was constructed in such a way, and with the use of some materials that compromise safety, security and confidentiality. These issues have been detailed in numerous reports. DJS lacks the resources to make all of the needed changes immediately but has been taking steps to begin to correct some of the problems. Suicide proof beds will be placed in six sleeping rooms as a start to replacing all of the beds. The desks and stools will be removed from those six rooms, as they have potential tie off points from which a youth could attempt a suicide. Also, the long sink handles from which youth have made weapons are being removed so that no handle is available and only a knob is used to turn on the water.

At times, youth awaiting placement have stayed many months at the Western Maryland Children's Center. These are often difficult to place youth. Area 3 Community Service staff and WMCC staff meet every Tuesday to discuss the youth in the Center, especially focusing on the youth that are hard to place or who have been in the facility longer than 30 days. This process is helpful, but not always successful in expediting a youth's placement beyond WMCC.

It is the practice on ASSIST to begin the counting of a youth's time in the facility over each time the youth goes to court and returns under a different status. A youth may be at WMCC "pending a hearing" for a month or longer, go to court and return under the status "pending placement". At this point ASSIST would begin the count again, by listing his enrollment date as the date he returned under the new "pending placement" status. Also, it has been practice to begin the accounting of time over when a youth transfers from one detention facility to another detention facility. This procedure gives an inaccurate and deflated accounting of how long the youth has actually been continuously in detention.

- The process of acquiring certification for new hires is very lengthy, sometimes taking eight to twelve months. This process should be reviewed to determine if the elapsed time between hiring and certification can be shortened.

Response:

Efforts are being made to reduce the length of time it takes to certify new hires. Beginning January, 2006, additional staff will be dedicated to CIJIS to process new applicants within 2-3days.

- Communication between DJS facilities is sometimes lacking, and should be conducted in a manner that ensures the transfer of all necessary information concerning youth.

Response:

The Department has developed a new form and procedures for the transfer of youth from one facility to another. This new procedure had been extremely effective in providing the information necessary for a smooth and informative transition.

- **Unabated for 30 Days or More:** The way in which youths' days in detention are tracked on ASSIST is misleading as it does not report the length of time a youth has been continuously in detention. The Department's policy should be changed so that ASSIST reflects the total length of continuous time a youth has been detained by DJS.

Response:

This recommendation has been taken under advisement.

- **Unabated for 30 days or More:** The Department committed to a remediation plan in January 2005 to: replace the vitreous china fixtures with stainless steel in no less than two bedrooms immediately; replace the vitreous china fixtures with stainless steel upon any breakage or damage; and retrofit the remaining vitreous china fixtures with stainless steel within a three-year period. None of the dangerous items has been replaced with a suitable fixture.

Response:

An engineering firm has been selected from DGS to complete an assessment of existing plumbing fixtures installed in the youth sleeping rooms and common areas. They will prepare a report and recommendation to the Joseph Tiberi, Maintenance Chief.

- **Unabated for 30 Days or More:** Unsafe ADA rails have not been modified and therefore, continue to present a danger to youth as they provide a potential tie off point for a suicidal youth, and may be pulled off the wall as used as a weapon.

Response:

The ADA rails are suicide resistant according to the design. However WMCC will research railings for possible replacements.

- **Unabated for 30 Days or More:** The sprinkler heads are not tamper proof and youth have managed to set them off resulting in flooding to the unit.

Response:

The sprinkler heads are tamper resistant per the design.

- **Unabated for 30 Days or More:** WMCC is still in need of 20-30 additional video cameras. As of yet, there is no recording capability at all in the facility using the existing cameras. There has been some discussion with Verizon to address the problem, but as of yet there is not definitive agreement.

Response:

As assessment was completed but funding for additional cameras has not been approved by legislation for FY06.

- **Unabated for 30 Days or More:** Tinting of the control room windows to provide confidentiality and safety has not been completed, though reportedly it has been approved for installation.

Response:

The control room windows have been tinted.

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

Response:

This recommendation will be taken under advisement.

- **Unabated for 30 Days or More:** On sleeping units A and C, there is no perimeter fencing to prevent someone from the outside from walking up to youths' sleeping rooms. This presents a breach of confidentiality and privacy. The Department has installed tinting on two of the windows, but it still may be possible to see into the rooms from the outside.

Response:

One-way glass is being installed so that no one will be able to look in the windows.

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 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.

- **Unabated for 30 day or More:** The facility continues to operate with a staffing shortage. The facility has three living units that house up to 18 male youth and 6 female youth. Each unit has two staff members assigned to work during the day and evening shifts. The two smaller pods have single staffing on the midnight shift. When more staffing can be hired, all shifts will have double coverage.

Response:

Four Resident Advisor positions and one Group Life position, have been filled, thus allowing for double coverage for all pods, Position testing has been scheduled and budgeted by HQ, and additional positions will be filled as soon as the hiring process is complete.

- In April, the facility had one group disturbance and three youth on staff assaults. The facility supervisors are no longer assigned to one area, allowing them to be available to monitor all youth and staff, as well as respond to emergencies. Also, the facility supervisors are no longer assigned to one area. This allows them to be available to monitor all youth and staff, as well as respond to emergencies.
- One new supervisory position has been filled and three additional direct care staff have been hired. The additional staffing allows for youth in seclusion to be provided a one-hour recreation period.
- Within the past month, the facility has remained at almost full capacity. For a few days, the population reached 26 requiring two rooms to sleep at double occupancy. Although each room was designed to house one youth, two male youth slept on stack-a-bunks on the floor.

Response:

This is the exception, not the norm.

- The youth are no longer taken to the dining hall to receive their evening snacks. The youth eat their snacks in the unit dayrooms to avoid youth on youth physical altercations occurring in the hallways.
- Youth are now being searched each time they enter the housing units as required by policy and detention standards.
- On July 1st, the Maryland State Department of Education (MSDE) assumed responsibility for educational programming in the LESCC. The youth will be

provided with six hours of daily instruction. A special education teacher and teacher's aide have been hired and should start in August.

- **Unabated for 30 Days or More:** The facility continues to operate without a Recreation Coordinator.

Response:

The request to fill this position was submitted on 6/6/05. We anticipate filling the position by September, 2005.

- As cited in previous reports, the facility lacks an enhanced evening program schedule. The case manager and addictions counselor provide some evening programming to the youth. However the facility superintendent states that a more structured evening program schedule is being formatted.

Response:

An enhanced evening program is being developed.

- The facility was designed to provide life skills training to the youth. The life skills room is equipped with a kitchen for cooking projects but cannot be utilized because the sink does not work. The facility superintendent stated that a staff member is currently developing a life skills program for the facility. A licensed cosmetologist is also developing a hair care program for the girls. Two nurses and a employee from the County health department provide health and nutrition classes for the youth.
- **Unabated for 30 Days or More:** The control center still does not have the ability to monitor the entire intake area by camera. The camera in the intake area is not able to pan the entire area.

Response:

Funding for the cameras has been deleted from the budget.

- Cameras will be installed in the classrooms by the end of this summer.
- The facility has received new, better quality two-way radios similar to the radios used at the Baltimore City Juvenile Justice Center.
- The facility had its 2nd Annual Fun in the Sun Cookout on June 10th for the youth and staff.