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OFFICE OF THE ATTORNEY GENERAL
JUVENILE JUSTICE MONITORING UNIT

**BALTIMORE CITY JUVENILE JUSTICE CENTER
SPECIAL REPORT**

Facility: Baltimore City Juvenile Justice Center
300 North Gay Street
Baltimore, MD 21201
Superintendent Johnitha McNair

Date of Incident : July 29, 2008

Date of Investigation: October 1 – 17, 2008

Reported by: Claudia Wright, Juvenile Justice Monitor

Issues Reported:

1. Threat to Life, Health and Safety of Youth and Staff
 - Failure to Respond to a Serious Group Disturbance
 - Improper Use of Restraint
 - Improper Use of Mechanical Restraints
2. Failure to Timely Investigate and Report a Serious Group Disturbance
 - Filing of Erroneous Reports
 - Premature Closure of Case
3. Failure to Timely Notify Child Protective Services of Alleged Child Abuse
 - Failure of Medical Personnel to Notify Child Protective Services
 - Delay of Notification of Child Protective Services by Office of Inspector General

Date of Report: November 1, 2008

EXECUTIVE SUMMARY

On July 29, youth at the Baltimore City Juvenile Justice Center participated in a group disturbance involving multiple safety and security issues – youth had both matches and cigarettes in their possession, lit paper on fire to set off the fire sprinklers, flooded the Unit, and eventually barricaded themselves inside. Over a two-hour period, staff observed this wide-scale disruption but did not intervene. When staff finally did intervene, all youth were physically restrained and placed in handcuffs. One youth was left handcuffed in the Unit without supervision for 20 minutes following the disturbance.

Youth examined by medical personnel following the disturbance alleged that staff had intentionally injured them, but none of the required notices to Child Protective Services were made. Staff completed an Incident Report but significantly misrepresented the magnitude of the disturbance.

The DJS Office of Inspector General (OIG) investigated the case but closed it on August 11 without interviewing any involved staff or youth or viewing videotape of the incident. On August 13, the CRIPA Monitor, DJS' Director of Quality Improvement, and an OIG Investigator noticed the event when reviewing random security videotapes during a CRIPA monitoring visit. An investigation ensued, and three staff were disciplined for failing to supervise youth and submitting false or erroneous incident reports.

Unfortunately, this incident is not an isolated occurrence. On October 7-8, ten youth barricaded themselves in a Unit of the Baltimore City Juvenile Justice Center for eight hours. The next evening, three youth again barricaded themselves in a case manager's office. It is clear that the Justice Center is in crisis - emergency measures, including those recommended in this report should be immediately implemented.

EVIDENTIARY BASIS FOR REPORT

Documents Reviewed

- Department of Juvenile Services Office of Inspector General Incident Reports 08-65858; 08-65855; 08-65889
- Pod E Unit 31 Log Books
- Department of Juvenile Services Office of Inspector General Report of September 11, 2008
- Review of Video of Pod E Unit 31, July 29-30, 2008

Persons Interviewed

- Superintendent Johnitha McNair
- DJS/OIG Staff

- DJS/BCJJC Staff
- State Trooper Frank Logsdon

STANDARDS APPLIED

Maryland Department of Juvenile Services Standards of Conduct 2.12 Prevention of Escapes and Disorders. *An employee shall take all reasonable means to prevent escapes or disorders.*

Maryland Department of Juvenile Services Standards of Conduct 2.13 Breach of Security. *An employee may not take any action or fail to take any action when the action or failure to act causes a breach of security or a potential breach of security by jeopardizing the physical security or integrity of an institution, or the physical security or integrity of any part or area of an institution or the safety or security of any employee, delinquent youth, offender, client, visitor or member of the public.*

Maryland Department of Juvenile Services Standards of Conduct 2.19 Reports. *An employee may not make any false oral or written statement or misrepresent any material fact, under any circumstance, with the intent to mislead any person or tribunal.*

Maryland Department of Juvenile Services Standards of Conduct 2.24 Attitude Towards and Treatment of Youth and Clients. *2.24.2 Every employee has a responsibility to ensure a safe and humane environment for youth and to respect the individual rights of youth and other clients.*

Maryland Department of Juvenile Services Standards of Conduct 2.25 Use of Force. *2.25.4 Every employee has an affirmative obligation to report any suspected violation of the child abuse or use of force policies of the Department to his or her supervisors or other superiors and to the appropriate law enforcement and child protective services agencies.*

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

Maryland Standards for Juvenile Detention Facilities 5.4.1.2 Protection from Child Abuse. *Youth shall be protected from acts of child abuse while in detention and incidents of suspected child abuse shall be reported by staff.*

Maryland Standards for Juvenile Detention Facilities 5.4.3 Mandatory Reporting of Physical Force. *Any personnel using physical force against any youth shall immediately file a written report with the facility's Program Manager setting for the circumstances of the act, the degree of force used, and the reasons for the use of force.*

Maryland Standards for Juvenile Detention Facilities 5.4.4 Absolute Necessity Required. *Physical force may only be used in circumstances in which it is absolutely*

necessary. Specific methods and techniques of physical intervention, which are recognized to minimize risk of injury to residents and staff, shall be used to physically control a resident.

Maryland Department of Juvenile Services MGMT-1-00 Reporting and Investigating Child Abuse. *To insure that youth under the care of the Department of Juvenile Justice are protected from abuse or neglect it is required that every employee report any suspected abuse or neglect, both orally and in writing, to the proper authorities.... There shall be a timely investigation by the appropriate authorities of each suspected incident of abuse or neglect.*

Maryland Department of Juvenile Services Policy and Procedure MGMT-03-07 Incident Reporting Policy. *The Department of Juvenile Services (DJS) employees... shall report and manage incidents involving a youth or program in a manner that provides for the public safety and the proper care, health, safety, and humane treatment of DJS youth. Additionally, DJS employees... shall notify law enforcement and the local Department of social Services (DSS) of incidents as required by law.*

Maryland Department of Juvenile Services Policy and Procedure RF-02-07 Use of Crisis Management (CPM) Techniques Policy. *Employees of the Department of Juvenile Services(DJS)...shall establish and maintain a safe and orderly environment within each facility. ... Crisis Prevention Management techniques may be utilized only to: protect or prevent a youth from imminent injury to self and others or to prevent overt attempts at escape. In the event that a youth remains an imminent threat to self or others and the youth's behavior has escalated, restraints or seclusion may be used as a last resort. Employees may not use CPM techniques, including restraints or seclusion, as a means of punishment, sanction, infliction of pain or harm, demonstration of authority, or program maintenance (enforcing compliance with directions).*

Maryland Department of Juvenile Services Policy and Procedure RF-05-07 Video Taping of Incidents Policy. *The Department of Juvenile Services (DJS) employees shall video tape room extractions, escorts to seclusion, use of restraints or other critical incidents that relate to the safety and security of a residential facility.*

Maryland Department of Juvenile Services Policy and Procedure RF-07-07 Post Orders Policy. *Department of Juvenile Services (DJS) residential facilities shall implement Post Orders detailing the duties and responsibilities for Direct Care, Transportation Employees and Security Officers. ... The Facility Administrator shall ensure that a sufficient number of employees are deployed appropriately to provide for the safety and security of the youth, employees, and facilities.*

STATEMENT OF FINDINGS

1. Threat to Life, Health and Safety of Youth and Staff

Conditions began to deteriorate on Unit 31, Pod E at about 7:00 p.m. on July 29, 2008. One youth, R.W. had been disruptive on the Unit since returning from court. At about 5:00 p.m., several staff attempted to process with R.W., but he was then restrained with handcuffs and placed in his room for about 15 minutes. He was taken to medical (for review since he had been restrained) and returned to Unit 31 at about 7:00. R.W. continued to disrupt the Unit. Two Resident Advisers (RA's) were assigned to Unit 31. Both Resident Advisers, and other staff who came to the Unit, attempted to calm R.W. and to carry on with scheduled activities.

By 8:00 p.m., other youth began to misbehave. At this time only the two assigned Resident Advisers were present on the Unit. The two RA's were attempting to assist youth to prepare for showers. Youth began to kick and bang on guardrails, and one youth was swinging a DVD player by its cord. One RA tried to attract attention of staff outside the Unit by knocking on the glass wall of the Unit. Youth began congregating in each others' rooms, horse playing, tearing up paper and throwing chairs. From 8:30 to 8:42 only one RA was on the Unit. By 8:40, the Unit was out of control, with youngsters dancing around and trying to get the female RA to dance with them. Youth R.W. urinated under the lower passage door. At 8:49, the female RA left the Unit for the night.

Department of Juvenile Services Policy specific to Baltimore City Juvenile Justice Center requires a ratio of one staff to six youth. From 8:51 until 9:15, one RA was alone on the Unit. By this time 8 youth were involved in destruction of the Unit (note at least two youth closed themselves in their rooms to avoid involvement) including setting off sprinklers, ripping down shower curtains and throwing chairs. Youth were smoking cigarettes and setting paper on fire to set off the sprinklers. An RA Group Life Manager appeared at the glass wall twice, but did not enter the Unit. Other staff members peered into the Unit as well, but did not provide assistance. At 9:09 youth started barricading the doors. The RA on duty in the Unit observed from the side of the Unit, eating potato chips, while furniture was piled in front of the doors.

During this time youth were tearing all the papers and posters off the walls, tearing up the logbooks, and spreading soap, lotion and water over the floors, walls and glass of the Unit. The purpose of covering the floors with slippery substances was to make it more difficult for staff to enter the Unit and restrain youth. At 9:15 and again at 9:20, the RA Group Life Manager entered the Unit briefly to deliver rubber gloves and towels. Remarkably, several youth put on rubber gloves and attempted to begin to clean up.

From 9:20 until 10:15, a period of nearly one hour, the one RA on duty was alone. He did not attempt to intervene to prevent the property destruction. At 10:15, five staff finally entered the Unit and began to try to calm the youth. Some youth began to

assault staff persons, and one youth was taken into the shower area and restrained. At 10:28, several youth realized that the Unit door was not secure and ran out into the Pod area. All the youth who were involved in the disruption were eventually restrained in the outer Pod area, were placed in handcuffs, and were removed to rooms in another Unit. One youth who did not move into the Pod area was left in the Unit, in handcuffs and without supervision, for almost 20 minutes. The two youth who had stayed in their rooms to avoid the disruption were taken out of their rooms and cleaned up the destruction on Unit 31 until 2:30 the next morning.

The DJS/OIG (Office of Inspector General) report states, “[T]his incident could have been prevented; multiple warning signs were present throughout a two hour span that should have alerted staff that a group disturbance could take place. Staff to include shift commanders and supervisors failed to respond aptly before this situation turned into an out of control, major group disturbance.”

Following the incident, involved staff members filed an Incident Report as required by DJS policy but described the incident as a 30 minute group disturbance which was quickly controlled rather than a major disturbance lasting several hours and involving significant destruction of the Unit.

As a result of this incident, three staff were disciplined.

2. Failure to Timely Investigate and Report a Serious Group Disturbance

According to the Incident Report that was originally filed, the incident described above was documented by involved staff in IR #65858 on July 29, 2008, at 11:20 p.m. The DJS Incident Report Data Base records the following:

- 7/31/08 9:34 a.m. record created
- 7/31/08 11:42 a.m. incomplete
- 7/31/08 11:43 a.m. pending approval
- 7/31/08 1:23 p.m. investigation pending
- 8/1/08 Under investigation
- 8/11/08 9:08 a.m. Under investigation
- 8/11/08 9:08 a.m. Closed Upon Review

On August 13, 2008, a random review of tour guard video by the CRIPA Monitor and DJS staff revealed that on July 29, Unit 31 was in complete disarray with chairs, tables and other objects scattered on the floor. A complete review of the video further indicated the extent of the July 29 incident. A new investigation took place and a report was provided to this Monitor on October 1, 2008. The Investigator concluded in that report that, “...Incident Report #65858 does not factually represent the numerous occurrences that happened on Unit 31 on 7/29/2008. Multiple incidents happened on 7/29/2008 but were not accurately reported.”

The OIG failed to fully investigate the events of July 29 during the period from July 31 to August 11. The OIG investigator did not review video or conduct interviews that would have revealed that IR# 65858 was erroneous. The OIG investigator responsible for BCJJC explained that she was simply overwhelmed with work during that period of time. The Director of OIG also failed to remove IR#65858 from the Incident Report Database when it was discovered to contain erroneous and misleading information. Despite requests from this Office, an incomplete and misleading Incident Report remains on the Database.

3. Failure to Timely Notify Child Protective Services of Alleged Child Abuse

In the late evening and early morning hours of July 29 and 30, 2008, at least 8 youth who were restrained following the group disturbance were examined by medical personnel. In the medical reports of those examinations, three youth made statements that indicated potential child abuse. One youth stated, "I was bust in my mouth." Another said, "I was restrained and messed my fingers up." The third said, "I have scratches on my arms. I have aches." All injuries occurred as staff were restraining or handcuffing youth, yet medical personnel did not report these statements to the local Department of Social Services (DSS) office as required.

In the initial investigation of the group disturbance, OIG reviewed the medical reports but did not notify DSS. Further, in statements of youth involved in the incident that were taken on July 29, one youth stated, "...I seen staff take (a youth) into the restroom and when he came out he had cuffs on and blood running down his face." Another youth stated, "... I was out for about 5 minutes and then the staff started talking then they started assaulting us and I had no choice but to fight back." OIG did not report these allegations to DSS until August 13.

CONCLUSIONS

1. Threats to Life, Health and Safety of Youth and Staff

- Three DJS staff violated DJS Standards of Conduct and Performance 2.19.1; 2.19.1.1; 2.13; 2.13.1; 2.13.2. According to the OIG investigation, one staff member "...did not keep Unit 31 youth safe and secure and failed to respond in an appropriate manner to a serious group disturbance. [The staff member] also failed to document the incident listed above as well as other occurrences that happened on his shift on 7-29-08 in a factual manner."

A second staff member "... failed to keep youth safe and secure and was neglectful in leaving Unit 31 in a volatile situation without added staff to ensure stability. [The second staff member] failed to document this incident in a factual and detailed manner. [The second staff member] failed to supervise his staff in an efficient and effective manner by leaving a staff member out of ratio and not assisting in securing Unit 31 in a timely fashion."

A third staff member "...failed to maintain a safe environment and left Unit 31 in disarray and did not report the details of this incident or the events of 7-29-08 factually. [The third staff member] failed to supervise his staff in an efficient and effective manner on 7-29-08. [The third staff member] failed to assist staff members in securing Unit 31 in a timely fashion.

Staff improperly restrained a youth at about 10:25 p.m. when the youth was moved into the shower area, out of view of the video camera, to accomplish the restraint violating DJS Policy RF-02-07 (4)(a)(2) requiring that "employees shall video tape the restraint in accordance with the Department's Video Taping of Incidents Policy."

- Staff violated DJS Policy RF-02-07 (4)(a)(3) when youth R.W. was handcuffed and placed in his room without supervision at about 5:00 p.m. and again when another youth was handcuffed and left alone in the Unit for 20 minutes at about 10:45 p.m. The cited policy requires that staff "...maintain one-on-one supervision of the youth until the restraint is released."

2. Failure to Timely Investigate and Report a Serious Group Disturbance

- IR# 65858 was reported on the DJS Database as an incident of property destruction that had lasted only 30 minutes. In fact, the incident involved numerous acts of destruction and violence, contraband, injuries, seclusions and restraints that took place over a 3-hour period. As of this date, the erroneous Incident Report has not been corrected on the Database. The facts surrounding the July 29 incident were only discovered inadvertently, when the CRIPA Monitor was reviewing video along with DJS staff for other purposes. Once discovered, OIG conducted a full-scale investigation and issued a complete report on September 11. That report was forwarded to the Monitor on October 1.
- The Department of Juvenile Services Office of the Inspector General (OIG) is charged with investigation of critical incidents that involve injury to youth or staff, destruction of property or allegations of child abuse. In this case, according to DJS/OIG documents, a record was created on July 31. On August 1 documents indicate that the incident was under investigation and on August 11, 2008 the investigation was closed upon review. During this two-week period, OIG failed to review the video of the incident, or interview witnesses (including youth), sufficiently to discover that the Incident Report that had been filed on July 29 was erroneous.

3. Failure to Timely Notify Child Protective Services of Alleged Child Abuse

- Eight youth who were restrained on the evening of July 29 were seen by medical staff within a few hours after the incident. DJS Policy MGMT-1-00 requires that any suspected child abuse be reported to the proper authorities immediately.

Although three youth indicated that they received injuries while being restrained, medical staff failed to report any of these allegations as required.

- DJS/OIG reviewed the documentation of the medical examinations of youth who had been restrained in the incident. Allegations of child abuse were clearly stated by youth in the medical documentation. These allegations were not reported prior to the closure of the incident on 8/11. After the true extent of the incident was discovered on 8/13, the allegations were finally reported.

RECOMMENDATIONS

1. The Department must act immediately to significantly reduce the population at BCJJC. It is abundantly clear that incidents such as that described above are a direct and predictable result of too many youth in an oppressive environment without meaningful activity. The Department has indicated that a population of 48 is the optimum number of youth to be housed together in a detention facility.
2. No youth should be required to be housed at BCJJC for more than 21 days. The unhealthy combination of the oppressive environment, inability to provide outdoor or other meaningful activity, and inability to separate youth, results in an unacceptably dangerous situation. The architecture of the facility makes it very difficult to modify the environment. Limiting exposure to this environment for individual youth would alleviate the harm that the incident described here demonstrates. Further, limiting length of stay would immediately result in population reduction.
3. Youth to staff ratio must be maintained at all times. If insufficient staff are available to maintain ratio, the administration must institute emergency measures to bring in off-duty staff, or seek court approval to release youth.
4. Staff who violate life, health and safety standards should be removed from contact with youth until they are sufficiently re-trained, or they should be terminated. Staff who falsify incident reports regarding life, health and safety issues should be terminated.
5. The Administration of BCJJC would benefit from the implementation of a cohesive and comprehensive security policy. Piecemeal efforts have not been effective to slow the introduction of contraband into the facility. Further, gradual tightening of security (including a number of measures recommended by the Monitor) without careful planning to assist the staff and youth with the transition to increased control has served to raise tension levels. Security policy should be designed and validated by bono fide experts on problems associated with maximum security facilities, and should be implemented and monitored by a top level administrator with responsibility for system wide security.

6. The Administration of BCJJC must act to enforce its own standards regarding handcuffs, and must immediately retrain staff to use handcuffs to control youth only when permitted by standards.