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Director

STATE OF MARYLAND
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: April 1, 2009

Investigated by: Claudia Wright, Tanya Suggs and Philip Merson
Juvenile Justice Monitors

Reported by: Philip Merson

Issues Reported:

1. Child Abuse/Excessive Use of Force
2. Failure to Follow Proper Crisis Intervention Procedures

Date of Report: May 2009

OVERVIEW

On April 1, 2009 a youth was restrained at Baltimore City Juvenile Justice Center. The restraint resulted in severe injuries to the youth.[1] Baltimore City Department of Social Services Child Protective Services (CPS) substantiated child abuse charges against one staff member and the Department of Juvenile Services Office of the Inspector General (DJS/OIG) sustained violations of DJS policy against three staff persons.

The Juvenile Justice Monitoring Unit (JJMU) highlighted concerns regarding violence in a Special Report in February 2009.[2] The Monitor's 2008 Annual Report also documented disturbing increases in violence at BCJJC between 2007 and 2008. Youth on youth assaults increased by 31% (from 455 to 595), and youth on staff assaults increased by 178% (from 46 to 128). Group disturbances increased by 200% (from 15 to 45).[3]

We again recommend that the Department of Juvenile Services reduce population at BCJJC to no more than 48 youth in order to provide a safe environment for youth and staff. We also recommend that the Department reform its staffing model and re-deploy staff at BCJJC to ensure that only skilled and experienced staff are working with youth who are housed there.

EXECUTIVE SUMMARY

During the evening of April 1, 2009, a Residential Advisor (RA) in Unit 21 D Pod directed the youth who is the subject of this report to go to his room. The youth refused. This youth, along with others, ignored a series of staff directives and continued to play and tease the RA. He also persisted in trying to look out the windows of the Unit to signal friends in other parts of the Pod. During this period a second Residential Advisor was present in the Unit, but she did not provide assistance. The Group Life Manager who was the supervisor in charge of the Unit that evening also entered the Unit but failed to provide assistance.

The staff person eventually confronted the youth in an area where chairs were lined up against a wall. The RA pushed him towards the chairs. The youth fell back and the staff pushed him again. The youth fell into the chairs as the staff person fell on top of him and held him there until other staff finally came to assist. The youth struck his face on the chairs and both of his front teeth were knocked out. He also received a fractured nose, lacerations of the lip and loosened teeth.

DJS/OIG, the Maryland State Police and Baltimore City Child Protective Services initially reported no sustainable charges against staff or any evidence of physical abuse.

[1] DJS Incident Report and Investigation Number 09-72355
[2] Juvenile Justice Monitoring Unit (JJMU) Special Report released February 26, 2009
[3] JJMU 2008 Annual Report, Volume 1, pp. 25-28.

Subsequently, DJS reopened their investigation and sustained findings against three staff persons for conduct violations. At the urging of the Monitor, CPS subsequently interviewed the victim, reviewed the video and sustained findings against the staff person who restrained the youth for child abuse.

EVIDENTIARY BASIS FOR REPORT

Documents Reviewed

- Department of Juvenile Services Office of Inspector General Incident Reports and Investigation Report # 09-72355 (completed April 13)
- Maryland State Police Incident Report 09-65-4123 (filed on April 14)
- Review of Pod D Unit 21 video of April 1, 2009
- DJS Medical files
- Maryland State Police Criminal Investigation Report #09-65-4123

Persons Interviewed

- DJS/OIG Staff
- DJS/BCJJC Staff
- Maryland State Police Trooper
- Baltimore City Child Protective Services Supervisor and Investigator
- DJS Medical Personnel
- Victim Youth

STANDARDS APPLIED

Maryland Department of Juvenile Services Standards of Conduct 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 Policy RF-02-07: *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 RF-02-07.4.a(2): *(iii) Whenever possible, two or more employees shall be used while restraining a youth to help ensure safety and accountability. (vi) An employee authorized to use physical restraints on a youth shall:(c) Use only authorized CPM techniques.(d) Act without causing the youth pain or suffering.*

STATEMENT OF FINDINGS

1. Child Abuse/Excessive Use of Force

Video reveals that on April 1, 2009, at around 8:00 pm, several youth housed in Pod D, Unit 21 were walking around the unit, sliding down the handrails of the stairs, jumping over the hand railings and hiding from staff. A staff person was imploring youths to go to their rooms and lock down for the night.

The youth appears to be teasing staff, running and hiding under the steps. Other youth, staff and a supervisor can be seen walking through the area. At one point, the staff person tries to restrain the youth, but he either escapes or is released. There is no indication that the staff person requested assistance from any other staff or that any assistance was offered. A few moments later, when the youth is again heading toward the windows of the Unit, staff pushes him towards the chairs that were lined up against the wall. Then he pushes the youth on to the chairs. The staff falls on the youth and holds him down. During the fall, the youth struck his face against the chairs. At no point in the video did the youth appear to challenge or threaten the staff. No other staff voluntarily came to the assistance of the staff attempting to restrain the youth.

The injuries sustained in this incident were severe. Approximately 80 minutes after the incident, the youth was taken to the emergency room at the University of Maryland Medical Center. Doctors there attempted to re-insert his teeth, but the prognosis for recovery of the teeth was listed as “poor.” The youth also received stitches both inside and outside of his lower lip. Several other teeth were loosened. His nose was fractured.

At this time the youth is housed in the infirmary at Hickey and will need to have a number of additional medical procedures.

2. Failure to Follow Proper Crisis Intervention Process

The staff person had ample opportunities to obtain assistance from other staff and the supervisor during this incident but he chose to try and handle the situation by himself. A physical restraint may have been avoided if staff had utilized other staff and crisis intervention techniques to de-escalate the situation. The area used for the restraint (into chairs along the wall) was not conducive to the safety of either the youth or the staff. Pushing the youth prior to falling on him escalated the situation.

DJS policy provides that restraint may only be used “to protect or prevent a youth from imminent injury to self and others or to prevent overt attempts at escape.” In this case the youth refused to follow directions but did not pose a threat to himself or to the staff. DJS policy also prohibits the use of restraint as a “demonstration of authority or program maintenance (enforcing compliance with directions).” In this case, the video indicates that staff restrained the youth solely for those prohibited purposes.

RECOMMENDATIONS

1. The upper tier of the facility should be closed to youth. Staff persons are frustrated trying to get youth to comply with directions as the youth run up steps, slide down handrails and hide under the steps. Population at BCJJC should be reduced to no more than 48 youth.

2. The Department must improve the quality of staff supervision to ensure compliance with DJS policies and the law. Only highly skilled staff should be assigned to work at BCJJC.