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Director

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL
JUVENILE JUSTICE MONITORING UNIT

COLBOURNE GROUP HOME SPECIAL REPORT

Facility: Colbourne Group Home (now Hadden House)
4802 Haddon Avenue
Baltimore, MD 21207

Program Manager: Debbie Marini

Date of Incident: December 22, 2008

Reported by: Tanya Suggs, Juvenile Justice Monitor

Issues Reported:

1. Failure to Maintain a Safe and Secure Environment for Staff and Youth.

2. Failure of Staff and Administration to Properly Report an Incident.

Date of Report: April 8, 2009

EXECUTIVE SUMMARY

This report addresses an incident at the Colbourne Group Home for Boys (Colbourne) in which two youth allegedly sexually assaulted a third youth. Staff did not report the incident to the Department of Juvenile Services as required by regulation, nor is there any evidence that it was reported to Child Protective Services in a timely fashion as required by law.

Since the Juvenile Justice Monitoring Unit began monitoring Colbourne in January 2008, it has reported on a series of safety-related incidents and issues at the home. The numbers of incidents and their severity has escalated over the months (see 2008 Quarterly Reports [Individual Facility Updates] and 2008 Annual Report).

Despite recommendations from the Monitor's Office, conditions have not improved, particularly those relating to appropriate and professional staff supervision of youth. The Department of Juvenile Services has not taken action as required by COMAR 14.31.05.08 to require corrective actions or impose other sanctions on Colbourne.

Because serious safety incidents continue to occur, we urge the Department to take action to ensure the safety of youth placed at Colbourne as required by COMAR regulations.

EVIDENTIARY BASIS FOR REPORT

Documents Reviewed

- Department of Juvenile Services Office of Inspector General Incident Reports and Investigation Report # 08-69786
- Colbourne Group Home Log Book
- Baltimore City Police Report #08-8L099773

Persons Interviewed

- Colbourne Group Home Manager
- Youth victim
- CPS caseworker

STANDARDS APPLIED

COMAR 14.31.06.18.A.2(a)(b) *The licensee shall immediately notify the licensing agency, the contracting agency, and the placing agency of any critical incident…*

COMAR 14.31.06.18 A.3 *The licensee shall immediately notify, by the next morning, the placing agency and, unless inconsistent with the child's individual service plan, the child's parent, if a child is hospitalized.*

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.*

Family Law Article §5-704. Reporting of abuse or neglect – By health practitioner, policy officer, educator, or human service worker. *Each health practitioner, police officer, educator, or human service worker, acting in a professional capacity…who has reason to believe that a child has been subjected to abuse, shall notify the local (child protective services) department…*

STATEMENT OF FINDINGS

1. Failure to Maintain a Secure Environment for Youth

On December 21, 2008 three youths were in the game room of the Colbourne Group Home. According to the statement of the victim youth, two residents approached him, and one of them held the youth's hands behind his back while the other pulled down the youth's pants and exposed his genitals and buttocks. The two residents began to make sexual gestures and slap him on his buttocks. One of the residents stated that "he had a nice piece of meat and wanted to slap it, so it would turn red." The youth stated that he tried to get away but one of the residents pushed him into a closet and began banging his head on the wall. The two residents then threw water on the victim's face in an attempt to revive him. The youth remembers waking up on the couch with water on his face and chest area. [1]

At the time that the incident occurred, the youth were not under the direct supervision of the two staff who were on duty in the home. One staff was outside smoking a cigarette while the other staff was in another area of the home. The staff who had been outside reentered the home moments after the incident occurred. Despite seeing the youth lying on the couch with water on his face and chest, this staff did nothing until the youth revived and informed him of the incident.

Staff on duty that evening did not notify anyone of the incident. When informed of the incident the next day, Colbourne Administrators who arrived at the home failed to

[1] Youth statement from OIG report and police report (08-8L09973). The logbook does not give a detailed account of the incident. The incident reports are dated 12/22 and 12/29. Apparently the report is based on youth statements and the police report. Neither staff nor other youth witnessed the incident.

report the incident to DJS or to Child Protective Services as required by Maryland statutes and COMAR regulations.

The Group Home Manager stated that when he arrived at the home the morning after the incident, he read the logbook and found out what happened. He spoke with the youth who had been assaulted. He said that he then placed a call to the Colbourne parent company on-call service to report the incident. He also said that he called the police and CPS. Police arrived and arrested the two residents and the victim was transported to the hospital. There is no record of any call or report being made to Child Protective Services by the Group Home Manager on that morning.

According to the victim, two Group Home Managers interviewed him on December 22. The youth stated that the managers called the police officers. He was taken to the hospital approximately three hours after the police departed.

The two direct care staff involved were terminated during the first week of January.

2. Failure of Staff and Administration to Properly Report an Incident

Two incident reports were completed by the Group Home Manager. One incident report is dated December 29 and the other is dated December 22; however, based on the fax cover letter, the reports were faxed to DJS on January 12 and January 14 - over three weeks after the incident. Staff on duty at the time of the incident should have immediately notified their supervisor and the DJS on-call administrator and filed a written incident report by 9 am the next morning. They took none of these actions.

According to the DJS investigative summary, the incident was reported to the OIG investigator on January 6, 2009, over two weeks after the incident occurred. It appears that the only reason DJS became aware of the incident at that point was because a DJS Internal Monitor visited the home on January 6 and learned of the event.

The incident report prepared by Colbourne staff states that the DJS Area Director and Assistant Secretary were notified by phone of the incident on December 22. Both of the administrators listed have not worked for the Department of Juvenile Services for a number of years, making it appear that parts of the incident report were falsified.

According to the information that was provided to the JJMU Monitor by Baltimore City CPS, the incident was reported on January 12, 2009 - three weeks after the incident occurred.[2]

[2] The incident report fax cover to DJS is dated January 12 and January 14 - the same time CPS was notified.

RECOMMENDATIONS

JJMU has reported on a number of serious incidents at Colbourne this year, including:

1. Serious fire code violations;
2. Hiring of staff with backgrounds prohibiting them from employment as child care workers;
3. The repeated failure of Colbourne to have an on-site administrator who is a Certified Child Care Administrator as required by law.
4. Rundown living quarters, including graffiti and holes in interior walls, mildew and stained bathing areas, and a missing window (during the month of February).

Each time an issue has been reported, a minimal amount of corrective action has been taken – sometimes enough to correct the specific condition but nothing more. Although Colbourne said they would move to a new house with an improved physical plant in April, 2008, they did not move until late December, 2008. The new facility is called Hadden House Group Home.

Many problems are "rectified" by firing and replacing staff. The home has had numerous Group Home Administrators through the year – few staying for more than a couple of months.

This most recent incident is easily the most serious in the series. Failure to report a sexual assault within the facility, including the failure to report to the licensing agency, is egregious. The apparent falsification of portions of the incident report when it was finally submitted reflects additional poor judgment by those involved.

Mentor Maryland, the parent company of Colbourne, runs many other non-residential programs that receive high marks from those familiar with them. The Colbourne Group Home/Hadden House, which provides transitional short-term housing for youth, must be significantly and permanently improved.

If this cannot be accomplished, and DJS cannot be assured of the safety of youth it places there, the Department should consider other sanctions that COMAR requires licensing agencies to impose on licensees who repeatedly violate COMAR regulations. These steps are necessary to ensure the safety and well-being of youth in the custody of the Department.