



NICK MORONEY
Director

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

SPECIAL REPORT

CHELTENHAM YOUTH FACILITY

Facility: Cheltenham Youth Facility
11001 Frank Tippet Road
Cheltenham, Md. 20623
Superintendent: William Wilson

Subject: Escape on July 15, 2011

Reported by: Nick Moroney

Date of Report: September 2011



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October 5, 2011

The Honorable Thomas V. Miller, Jr., President of the Senate
Maryland General Assembly, H107 State House
Annapolis, MD 21401

The Honorable Michael E. Busch, Speaker of the House
Maryland General Assembly, H101 State House
Annapolis, MD 21401

The Honorable Sam J. Abed, Secretary
Department of Juvenile Services, One Center Plaza, 120 West Fayette Street
Baltimore, Maryland 21201

Rosemary King Johnston, Executive Director
Governor's Office for Children, Office of the Governor
301 W. Preston Street, Suite 1502
Baltimore, MD 21201

Members of the State Advisory Board on Juvenile Services
c/o Department of Juvenile Services, One Center Plaza, 120 West Fayette Street
Baltimore, MD 21201

Dear Mr. President, Mr. Speaker, Secretary Abed, Ms. Johnston, and State Advisory Board Members:

Enclosed please find a Juvenile Justice Monitoring Unit (JJMU) Special Report concerning an escape on July 15, 2011, from Cheltenham Youth Facility. The Department of Juvenile Services Response to the Special Report is included at the end of this document.

I would be pleased to answer any questions you may have about this report. I can be reached by email at nmoroney@oag.state.md.us and by phone at 410-576-6599 (office) or 410-952-1986 (cell). Current and previous reports of the Juvenile Justice Monitoring Unit are available via link on our website at www.oag.state.md.us/jjmu.

Respectfully submitted,

Nick Moroney

Nick Moroney
Director
Juvenile Justice Monitoring Unit

Cc: The Honorable James Brochin, Maryland State Senate
The Honorable Joan Carter Conway, Maryland State Senate
The Honorable Brian Frosh, Maryland State Senate
The Honorable Lisa Gladden, Maryland State Senate
The Honorable Nancy Jacobs, Maryland State Senate
The Honorable Edward Kasemeyer, Maryland State Senate
The Honorable Delores Kelley, Maryland State Senate
The Honorable Nancy King, Maryland State Senate
The Honorable James Mathias, Maryland State Senate
The Honorable Anthony Muse, Maryland State Senate
The Honorable Victor Ramirez, Maryland State Senate
The Honorable Robert Zirkin, Maryland State Senate
The Honorable Norman Conway, Maryland House of Delegates
The Honorable Kathleen Dumais, Maryland House of Delegates
The Honorable Adelaide Eckardt, Maryland House of Delegates
The Honorable Ana Sol Gutierrez, Maryland House of Delegates
The Honorable Susan Lee, Maryland House of Delegates
The Honorable Anthony O'Donnell, Maryland House of Delegates
The Honorable Samuel Rosenberg, Maryland House of Delegates
The Honorable Luiz Simmons, Maryland House of Delegates
The Honorable Nancy Stocksdales, Maryland House of Delegates
The Honorable Joseph Vallario, Maryland House of Delegates
The Honorable Jeff Waldstreicher, Maryland House of Delegates
The Honorable Nancy Kopp, Treasurer's Office
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EXECUTIVE SUMMARY

This Special Report focuses on an escape that occurred at Cheltenham Youth Facility (Cheltenham/CYF) in Prince George's County on July 15, 2011. Cheltenham is a secure detention facility serving young men ages 12 to 18 who are awaiting trial, adjudication, or committed placement. CYF is owned and operated by the Maryland Department of Juvenile Services (DJS/the Department). An average population of over 100 youths are housed in three aged detention units and a renovated infirmary.

The escape occurred at approximately 1 a.m. on the morning of July 15. It involved two youths who left from one of the detention units, Cornish Cottage, and apparently cut a hole in the CYF security fence. They walked for 3 miles and attempted to steal a car for transportation before being apprehended.

On the night of the escape, the two absconding youths were able to obtain a set of bolt cutters inside of Cornish Cottage. A door from the cell hallway into a room with an external exit door was unlocked. The room was formerly designated as a game room but was little used at the time of the escape. The external doorway from said room was also unlocked. Video footage indicates that lack of appropriate supervision enabled the youths to wander in and out of this room, in and out of the building, and back and forth along the cell hallway before they left the facility.

One of the youths can be seen testing bolt cutters on wire window mesh in the game room. One of the youths can be seen walking down the cell hallway to grab some shoes before going back to the game room and making a final exit from Cornish Cottage. Investigative reports indicate the youths cut a hole in the CYF fence and left on foot. They walked approximately 3 miles on Surratt's Road toward Southern

Maryland Hospital. They made their way along a winding road flanked by woods on each side and dumped the wire cutters along the way. Near the end of Surratt's Road, the youths reached Southern Maryland Hospital on their left, and a convenience store on their right. Then they attempted to get transportation by shouting at a driver to get out of her vehicle. The driver drove off, and informed hospital security and law enforcement. The youths were spotted and apprehended by police officers soon after a second attempt to procure transportation failed.

Staffers at CYF were unaware that any youths were missing until approximately 1:30 a.m. When the fence was cut, an alarm was activated on a computer in a control area at CYF. An incomplete fence check, conducted approximately 30 minutes after the CYF fence was breached, did not reveal the opening in the wire behind Cornish Cottage, and the alarm was cleared. No population count was taken at that point.

An existing community notification system should have been activated when it was known that two youths were missing. The system was not activated. The youths were apprehended at 2:30 a.m. by police officers and transported back to CYF. They were later transferred to other facilities. According to law enforcement officers, the youths, ages 17 and 14, are to be charged as adults with escape and attempted carjacking.

DOCUMENTS REVIEWED

1. Department of Juvenile Services Internal Incident and Investigative Reports:
DJS Incident Report 93624 and witness statements; DJS-OIG 11-93624 Escape Report; DJS-OIG Administrative report (July 27, 2011); and DJS-OIG 11-93624 Escape Report Addendum (August 11, 2011)
2. MDSP Criminal Investigation Report 1161006016
3. Cornish Cottage Log Book
4. Cornish Cottage Schedule
5. Electronic Tour Guard System Log
6. Cheltenham Youth Facility Operating Procedures (CYF-FOPs):
FOP 002 – Physical Count Procedures
FOP 004 - Supervision and Movement
FOP 031 - Escape or Attempt to Escape
7. Three separate documents numbered as CYF-FOP 032 were also reviewed:
Required Use of Tour Facility Monitoring System (11-3-09)
Key Control Procedures (3-1-11)
Physical Count Procedures (3-21-11)
8. Community Alert System instruction sheet
9. DJS Memo dated 6/23/08: “Notification Process after an Escape.”
10. Relevant DJS Standards, Policies and Procedures

FINDINGS

Security camera footage, police reports and internal DJS reports and interviews indicate that, on the night of July 14 - 15, 2011, two youths in Cornish Cottage detention unit at Cheltenham Youth Facility:

- moved in and out of their unlocked CYF cells and around the hallways of a detention unit without supervision
- entered and exited an off-limits room at will through a cell hallway door which should have been locked
- maintained access to a working land line telephone which was concealed within piles of laundry in the off-limits room
- exited the detention unit from the off-limits room through an unlocked door
- retrieved, tested and, once outside the unit, used a large set of bolt cutters to cut the CYF fence and leave the facility

According to the Cornish Cottage schedule, lights-out time for those with level 4 (highest) privileges is 10:30 p.m. The unit log book includes a shift change and youth count at 10 p.m. on July 14, 2011. It was during this 10 p.m. to 6 a.m. shift on July 14/15 that the escape occurred.

Between 10:04 p.m. and 10:08 p.m., some youth in Cornish moved up and down the cell hallway and in and out of an off-limits but unlocked room called the game room. The room should have been locked and the youth should have been closely supervised.

At 10:20 p.m., a youth hid a landline telephone among a pile of bed sheets on the floor of the game room. A staffer entered and ordered the youth out, however, the

staffer did not lock the game room door. Another staffer entered an honors cell occupied by the youths subsequently charged with escaping. The cell had a television and DVD player. This staffer spent time watching a movie and watching youths who were heading to the restroom and getting ready for bed. By 11:25 p.m., all residents were in their cells and this staffer was back in the cell with the TV.

CYF policy stipulates a check on youth every 10 minutes at night. DJS policy mandates staff check on youth a minimum of every 30 minutes during the night shift.

From 11:30 p.m. until after the escape, there were two staffers on the Cornish unit. The person watching TV left the honors cell and returned with a coat at approximately 11:50 p.m. The staffer later admitted falling asleep while watching a movie. The second staffer spent most of the time at the front of the unit and away from the youth.

Just after midnight, one of the youths later charged with escape “walked down the back hallway unescorted by staff and entered the Game [R]oom” where he “checked to see that the exit door was open ... got out a phone and plugged it into the outlet.” The phone had been spotted by another CYF staffer on July 13 but had not been confiscated from youth or even reported. Asked why, the staffer said, “I did not want to get in any trouble” (DJS-OIG 11-93624 and Addendum).

Between 12:15 and 12:20 a.m., one of the youths entered the game room through the unlocked door at the end of the cell hallway. The youth drank some juice and left the room at approximately 12:25 a.m. He walked past the seated staffer and wandered to the restroom area and back again to the cells. Between 12:35 and 12:40 a.m., both youths wandered the cell hallway unsupervised. One of the youths retrieved a set of bolt cutters.

At 12:47 a.m., the youths exited to the outside of Cornish Cottage through a second unlocked door. This door should also have been locked.

The youths came back in to the game room. One of the youths walked to a metal window guard and tested the effectiveness of the bolt cutters.

One of the youths left the room, made his way past the sleeping staffer, and retrieved shoes for both youths before returning to the game room.

At approximately 12:54 a.m., the two youths used the external exit door to leave the Cornish Cottage game room for the facility fence area.

According to police reports, bolt cutters were used to cut a hole in the fence. The youths moved along the fence line and toward Surratt's Road and Southern Maryland Hospital.

The perimeter fence alarm was activated but "was not acknowledged by [the staffer] assigned to the Tour Office [facility control center] until 1:16 a.m." The gatehouse controller notified a security staffer who "viewed the fence line" near Cornish but "failed to walk over to the fence and examine it closely," notifying the gatehouse worker that the area was "clear and secure" (DJS-OIG 11-93624).

Wandering is required on the night shift at CYF. Wandering in this case means looking in cells to assure youth are safe and using an electronic tool called a wand to document the check. According to an entry in the Cornish log book, the staffer in the cell hallway was wandering for three hours - from 10:30 p.m. to 1:30 a.m. However, security cameras inside Cornish did not record any movement between 12:54 a.m. and 1:30 a.m. Electronic records show staff in Cornish did not wand between 12:14 a.m. and 1:30 a.m.

The Cornish log book has four notations between 11:30 p.m. and 12:30 a.m. documenting the unit as “safe and secure.” The next note was written after 4 a.m.

At approximately 1:30 a.m., the staffer who had been at the front of the unit walked back to the cell area, saw the sleeping staffer and began checking cells and wandering. The staffer with the wand walked to the end of the cell hallway and looked into the unlocked game room and then walked over to confer with the seated staffer. The two staffers began looking around the hallway, then walked into the game room and out the unlocked external game room door to the outside, leaving the unit entirely unsupervised for a few minutes.

At 1:35 a.m., a security officer from Southern Maryland Hospital “called the facility and asked if there had been any escapes?” The caller told CYF staff there had been “... an attempted carjacking ... and the suspects were young males and wearing all gray clothing.” The staffer who took the call informed the shift supervisor (DJS-OIG report 11-93624).

At about the same time, the Cornish staffers came back into the game room and closed, but did not lock, the external door before going to the cell the two missing youths had occupied. A few minutes later, one of the staffers walked to the front of the unit and began making telephone calls.

After the staff supervisor was told about the call from the Southern Maryland security officer, the supervisor called Cornish and was told about the two missing youths. The supervisor came to Cornish and looked around the cell hallway, the game room and the fence behind Cornish. After re-entering the unit, the supervisor worked with staffers to

close and lock doors and conduct a head count before leaving Cornish for the Tour Office to begin making notifications (DJS-OIG report 11-93624).

At 2:30 a.m., the missing youths were found and taken to a police station in Clinton. The youths had been missing for approximately one and one-half hours. They were brought back to CYF by Maryland State Police at 3:42 a.m.

The Maryland State Police interviewed the two CYF staffers who had been on duty in Cornish at the time of the escape. The staffer who had been in the cell hallway admitted he had been sleeping. According to the DJS-OIG report on the escape, the staffer “admitted to falling asleep while watching a movie” and also “to falling asleep a second time as [the staffer] sat down in the chair in the hallway” (DJS-OIG report 11-93624).

The shift supervisor told investigators that supervisory rounds were not made to Cornish “prior to the escape.” After learning that youth were missing, the community alert system was not activated because the supervisor “had forgotten how to activate the City Watch Alert” and couldn’t find instructions (DJS-OIG Report 11-93624).

In the event of an escape, DJS employees must notify law enforcement immediately, activate the community alert and inform DJS leadership: “The above steps should take place within minutes of each other. Each facility should have a designated person(s) on each shift who is responsible to ensure that this process is followed” (Notification Process after an Escape - Memo sent from DJS-HQ on 6/23/08).

The supervisor did contact an off-duty manager about the problem but, by the time other administrative staff who could have activated the system had been alerted and arrived at CYF, the police had already apprehended the two youths.

The bolt cutters used to cut the CYF fence were found in the vicinity of Surratt's Road on July 15 after the two youths were apprehended. The question of how the cutters came to be in the Cornish Cottage on July 14 has been investigated but has yet to be conclusively ascertained.

After internal DJS investigation of the escape, a number of CYF direct care and management staff were subject to disciplinary action up to and including termination of employment.



Game Room in Cornish Cottage showing the door to the outside which was left unlocked

CONCLUSION AND RECOMMENDATIONS

Before and immediately following the escape of two youths on July 15, workers at Cheltenham failed to follow basic supervisory, safety and security procedures. Doors were unsecured. Youth were not properly supervised by direct care staff. Direct care staff were not properly supervised by a manager.

One staffer was at the front of the unit, out of sight of the youths, until after the escape. The other staffer was in the area where youth sleep but spent a portion of the shift watching TV and sleeping on duty. Staff should have been awake and alert and checking on youth at least every 10 minutes in accordance with facility procedures or, at a minimum, every 30 minutes as mandated by DJS Policy and Procedure.

The supervisor and direct care staffers responsible for the Cornish Cottage unit at the time of the escape were experienced workers who had worked at Cheltenham for a number of years. Two youths were nevertheless able to prepare and leave Cornish during a period of approximately one hour when there was a complete lapse in safety, security and supervisory procedures. The situation was exacerbated when a fence alarm was not promptly and comprehensively addressed.

Awareness and action on the part of staff and management to ensure youth are always appropriately supervised and doors always secured are fundamental to the safe operation of any detention facility.

Staff must adhere to security and safety procedures and requirements involving youth supervision, staff tool inventory requirements, key/lock control requirements, contraband, and perimeter patrol requirements including fence checking. Security equipment should be checked to ensure it is functioning. Staff must respond to alarms

quickly and appropriately. Community reporting in the event of an escape must also be accomplished without delay.

Administrators, staff and supervisors should be trained and retrained to ensure:

1. All youth are supervised by direct care staff at all times.
2. Entry and exit points are always secured.
3. Youth counts are conducted on time and with accuracy.
4. Thorough searches are performed regularly and without prior notice.
5. Duties on unit are carried out appropriately and documented in the unit logbook.

The Cheltenham facility is outdated, overcrowded and inappropriate for youth residence. While CYF is scheduled to be replaced by a new detention facility at the same location, that facility is still years from completion. In the meantime, the current facility at Cheltenham should have comprehensive security camera coverage. Cheltenham administrators currently use computers to access camera footage. Security camera monitors should be installed at various control and administrative locations to facilitate real-time 24-hour monitoring of activities throughout CYF.

APPLICABLE STANDARDS

Md. Dept. of Juvenile Services Standards of Conduct 2.10 Performance of Duties

An employee of the Department shall be responsible for his or her own actions, as well as the proper performance of his or her duties....

Cheltenham Youth Facility Operating Procedure - FOP 004 (1-12-05): Supervision and Movement. Procedures. Supervision of Youth in the Building. 1. *All staff are responsible for maintaining sight and sound supervision of assigned youth inside as well as outside the building at all times... 6.* *All unit rooms shall be monitored for physical condition, youth presence, and any unusual behavior. Any discrepancies shall be documented and a supervisor notified... 9.* ***During sleeping hours, staff shall make visual checks of youth at least every 10 minutes... [Bold type in original]***

Cheltenham Youth Facility Operating Procedure - FOP 032 (11-03-09): Required Use of Tour Facility Monitoring System. I. Purpose. *To ensure safety and welfare during the overnight hours or when the youth are confined to their rooms with the door locked. The residential staff visually checks each resident every 15 minutes, or more frequently, as ordered by supervisory, mental health, or health care staff. Each living unit of the CYF will utilize an electronic monitoring system to document the visual checks of each youth and designated areas of the facility.*

Md. Dept. of Juvenile Services Policy and Procedure RF-04-07 Safety Inspections Policy (Residential Facilities) General Procedures 4.a.(2) *All employees shall be constantly observant of the condition of the facility, including security devices and safety concerns. Any deficiencies observed shall be reported to the Facility Administrator.*

Md. Dept. of Juvenile Services Policy and Procedure RF-09-07 Perimeter Security Policy *The Department of Juvenile Services (DJS) residential facilities shall ... maintain youth within the perimeter by ensuring all security perimeter entrances and exterior doors are kept locked.*

Md. Dept. of Juvenile Services Policy and Procedure RF-02-06 Youth Movement and Counts Policy (Residential Facilities) 4.a.(3) *Each Facility Administrator will ensure that a physical count is taken, at minimum, every 30 minutes... 4.a.(4)* *The Resident Advisor shall conduct counts every 30 minutes and call the count into the Command Control Center/Master Control/Tour Office. The count must be logged in the unit logbook within 15 minutes of the count. 4.a.(5)* *When conducting counts, employees must count an actual person... 4.a.(8)* *All employees will be responsible for conducting accurate counts and controlling youth movement... 4.a.(9)* *The manager on duty will oversee each count conducted including determining if the count is accurate... 4.a.(11)* *Employees conducting counts during the third shift must verify that the youth are in their beds.*

APPLICABLE STANDARDS (continued)

Cheltenham Youth Facility Operating Procedure - FOP 002 (Revised 03-21-11): Physical Count Procedures. II. Definitions: Informal Count *Physical counts of youth conducted by staff at times other than official count time ... every 10 minutes during sleeping hours ... Informal counts will be logged in the unit logbook...*

Md. Dept. of Juvenile Services Policy and Procedure RF-09-05 Command Control Centers Policy (Residential Facilities) Duties and Responsibilities 4.b.(1)(vi) *Employees shall: ... maintain perimeter monitoring to assure security or provide warning of a security breach; ... (viii) Activate and use operational video or other monitoring devices to maximize the ability of personnel to observe or otherwise monitor activity within or surrounding the facility ...*

Md. Dept. of Juvenile Services Policy and Procedure RF-06-05 Key Control Policy (Residential Facilities) General Procedures: Issuance and Maintenance of Keys 4.d.(6) *No employee will alter or change locking devices or doors without authorization from the Facility Administrator.*

Md. Dept. of Juvenile Services Policy and Procedure RF-06-07 Searches Policy (Residential Facilities) Procedures: Room Searches 4.e.(3) *Room searches will be conducted a minimum of once per week ...* **Searches of General Areas 4.f.(2)** *General areas ... shall be searched a minimum of once daily.* **4.f.(4)** *All doors, particularly doors to youth rooms, and security grills shall be inspected at minimum once per shift to detect any tampering or defects.* **Searches of Perimeter and Grounds 4.g.(2)** *The search shall consist of a visual inspection of the entire outer perimeter and grounds to ensure that there are no immediate breaches of security or visible contraband. (3) Employees shall search fences, fence lines, buildings and immediate grounds adjacent to the facility or program, as well as internal and external buildings and structures.*

Cheltenham Youth Facility Operating Procedure - FOP 031 (Revised 03-31-11): Responding To a Successful Escape. Tour Office. III.d.2. *Activate the City Watch Notification System within 30 minutes.*

Md. Dept. of Juvenile Services Policy and Procedure RF-05-06 General Documentation of Log Books (Residential Facilities) Purpose of a Log Book 4.b.(10) *Each entry in the log book represents an official, permanent record and is a legal document... There shall be no erasures or crossed-out sections which cannot be read as a result of being crossed-out.*

Md. Dept. of Juvenile Services Policy and Procedure RF-04-05 Video Surveillance Cameras (Residential Services) *Department of Juvenile Services shall utilize video surveillance cameras in residential facilities as an additional safety and security measure, which can serve to electronically document daily activities in a facility.*



Maryland Department of
Juvenile Services
Treating • Supporting • Protecting

October 4, 2011

DJS Response to Cheltenham Special Report

On July 15, 2011, two youth detained at the Cheltenham Youth Facility (CYF) escaped from their living unit in the middle of the night through a back door that was left unsecured by staff error. The youth then used bolt cutters to cut a hole in the fence and flee the secure campus. The youth were quickly apprehended by law enforcement and after questioning sent to different detention facilities to be held. They have both subsequently been charged with escape.

The Secretary and Deputy Secretary of Operations were on-site with the Superintendent upon learning of the incident in the early morning hours to assist staff and investigate firsthand the deficiencies that lead to the security breach. It was concluded that the proper policies and procedures were in place to prevent this type of incident but the staff failed to follow them. A mandatory staff meeting was held and led by the Superintendent that same morning. All security procedures were reviewed and reinforced with staff. Details of the security breakdowns which allowed the escape to occur were shared with staff to highlight deficiencies. Procedures for the inventory and control of tools have been established for maintenance staff. Disciplinary action, up to and including termination, was taken against all staff who failed to follow the Department's policies and procedures.

There has also been a change in leadership at Cheltenham. Mr. Anthony Wynn, who was formerly the Superintendent at the Baltimore City Juvenile Justice Center (BCJJC) has assumed the duties as Superintendent. Mr. Wynn has been recognized for his leadership and staff development while at BCJJC. Mr. Claude Waters has also assumed the responsibilities as Assistant Superintendent of Operations.

Per policy, DJS immediately conducted an investigation through the Department's Office of the Inspector General. The investigation has been completed and all the findings and recommendations identified in the investigative report have been addressed. Additional security measures are also being implemented.

The bullets below provide a summary of the completed corrective actions:

- An immediate inventory and security sweep was conducted to ensure all tools were accounted for. Maintenance has increased their random inventory audits to ensure the tool control policy is being enforced.
- The Superintendent debriefed with all staffed involved and addressed their actions that contributed to the incident.
- Disciplinary action was taken against all staff who failed to comply with the Department's policies and procedures.
- A follow up review of video footage and a walk through of the facility was conducted to identify blind spots within the video surveillance system. Additional cameras have been ordered and will be installed within the areas identified.
- All equipment and fence alarms were tested to ensure they were functional and will be continuously checked by staff when they assume their post, using a checklist.
- Alarms for the doors in the living units have been ordered and will be installed.
- CYF staff were re-trained on the following policies and procedures:
 - Requirements for youth supervision;
 - Movement;
 - Log book documentation;
 - Tool control;
 - Radio checks;
 - Youth counts;
 - The Community Notification System; and
 - The Housing Unit Staff Post Orders (which includes staff notification and approval from the Shift Commander prior to letting a youth out of their room).
- Executive level staff have increased oversight as well as unannounced administrative visits on both night and day shifts.
- Shift commanders were directed to increase rounds per shift and areas that need to be covered.
- Additional Gators (similar to golf carts) have been assigned to the facility to assist in perimeter control.
- Increase in the frequency of random video recording reviews by facility management to ensure staff is conducting room checks, youth counts and other security procedural requirements daily.

Conclusion

This particular incident would not have occurred had the staff followed DJS policies and procedures that were in place. To prevent similar incidents from occurring in the future, DJS has (1) taken appropriate disciplinary action and (2) redoubled its training efforts, so staff is clear about the procedures that should be followed. The goal of the Department is to ensure that DJS employees comply with the policies and procedures so DJS facilities are safe. We are committed to providing the ongoing training, oversight and accountability that is needed to improve compliance with procedures.