Justice Monitoring Unit
Central Area Quarterly Report for July-September 2006

THE BALTIMORE CITY JUVENILE JUSTICE CENTER (BCJJC) is a State detention facility that has the capacity to *safely* house 108 youth; however, once a suicide resistant barrier is completed for the second tier, the facility will be able to safely house its designed capacity of 144 youth. The Maryland State Department of Education provides instruction to the youth at the facility.

STAFFING:

Unabated for 30 or More Days:

Population:

The facility is rated for a maximum population of 144; however, only 108 youth can be housed safely until the second tier railings are suicide proofed for 3 more units. Although DJS data indicates the population decreased to a daily average of 140 during this quarter, this monitor observed populations from 133 to 162. There were severe concerns with overcrowding at the beginning of this quarter when the population reportedly reached 168, but the administration had drafted a procedure that formally utilized the infirmary, intake area, interview room and open area of the unit for sleeping up to 24 extra youth and use of the gymnasium if it became absolutely necessary.

Unabated for 90 or More Days:

Staff/Youth Ratios:

Overtime staff is being used to try and maintain a 1:6 staffing ratio.

- On July 20, 2006, this monitor observed the Unit Roster Count Sheets from the 7:00 AM time period. There was 2 staff on each unit except for 3 of the units that had only 1 staff – each with 12 youth.
- On August 20, at 7AM all units except for 2 had 2 staff working. Those 2 units with single staff coverage each had 12 youth assigned.
- On September 13 there were 133 youth at the facility and every unit had 2 staff working.

For safety of both the youth and the staff, this office promotes having 2 staff persons on every unit, regardless of the number of youth assigned to the unit. See the incident in the "Aggressive Incidents" section of this report that describes an assault on a youth due to staffing shortage.

DJS Response:

BCJJC safely houses all youth that enter the detention center. DJS is in the process of exploring funding sources to complete the remaining six units. However, it should be noted that DJS affirms that youth are safely housed. We fell the resistant barrier will further enhance youth safety.

BCJJ will maintain a 1 to 6 staff to youth ratio during waking hours and a 1 to 12 ratio during sleeping hours. The above mentioned ratio (1 to 6 and 1 to 12) meets safety and security requirements set at the facility and department level. Also, this staff to youth ratio is in line with nationally accepted standards.

Unabated for 180 or More Days:
Master Control Staffing:
Master control should be staffed with 2 persons at all times, unless someone is working the floor control station. There continues to be a need for more personnel to reduce the stress placed on a single staff working in master control. Master control staff must deal with the security system (cameras and doors), radio, phones and visitors/staff requesting assistance outside the master control area (at the window), logs and population movement. The floor control room is often not manned due to limited staffing and that places additional responsibilities on the master control staff.

DJS Response:
BCJJC has already assigned three control operators for 1st and 2nd shift and 2 staff members on 3rd shift at BCJJC. These assignments allot for at least two (2) control room operators to be present 7 days per week on 1st and 2nd shift and at least one for 3rd shift. Managers have been directed to maintain these ratios 24/7 daily and to use drafts if necessary to maintain these levels.

Unabated Since June 30, 2004:
Restraint Training:
There is still no agreement in effect and no trainings have taken place for DSS, DJS and State Police investigators relating to the proper use of restraints in DJS facilities.

DJS Response:
DJS will provide the monitor with the time frames for this training once it is finalized. Currently, the recommendation for Crisis Intervention and Restraint Training for DSS, DJS and MSP investigators is being reviewed carefully and a decision is still pending. While DJS is willing to accommodate the actual training, this is not a DJS issue. This request should be directed to DSS and MSP.

Unabated for 180 or More Days:
Identification and Professionalism:
In the event that a staff person's identification is necessary by staff, monitors or youth, it is difficult to determine without asking other staff and/or compromising privacy. Some type of nametag should be worn so staff persons are immediately identifiable. This would also be a more professional way of identifying staff. Administration at the facility has completed the necessary paperwork to have staff obtain updated identification cards but due to staffing requirements, there have been delays in scheduling the appointments for having the photographs taken.

DJS Response:
Staff at BCJJC have expressed concern of having their first name displayed to youth and firmly believe youth will call them by there first name instead of there last name as is the practice. Staff and management are opposed to wearing name tags. However, state issued I.D cards have been requested and we are awaiting a response. Also, the Independent Monitor is escorted around the building during visits by the facility administrator or designee and those persons can easily identify any staff person for the Independent Monitor.

Unabated for 90 or More Days:
Hiring and Processing for New Staff:
The facility has been actively interviewing and hiring staff for the facility; however, there appear to be problems with high turnover and the processing time required to bring new staff on. Some steps might be consolidated to expedite the hiring process. After the background investigations are completed on candidates, fingerprinting, drug testing and psychological testing could be done on the same day. Oral interviews for those eligible candidates could be completed on a subsequent day.

DJS Response:
The phrase "problems with high turnover" is not an accurate statement and in fact per the Department of Justice, "typical vacancy rates for effective juvenile facilities range from 5%-12% of its budgeted staffing levels." BCJJC falls within this above stated rate.

SAFETY AND SECURITY:
Unabated Since June 30, 2004:
Detention/Pending Placement Youth:
According to the facility's Population Reports the following tables indicate the numbers of youth on pending placement (post adjudicated) and on detention (pre-adjudicated). These tables also indicate the numbers of youth who have been detained or committed in the facility for longer than 60 days, longer than 100 days and longer than 200 days.

Pending Placement (PP):

Date	PP Total	60+ Days	100+ Days	200 + Days
July 19, 2006	33	14	12	1
August 21, 2006	45	18	9	1
Sept. 12, 2006	23	12	8	2

Detention:

Date	Detn Total	60+ Days	100+ Days
July 19, 2006	122	6	
August 21, 2006	90	6	1
Sept. 12, 2006	109	20	5

It appears that more youth are spending longer periods on pending placement and in detention. On August 21, this monitor conducted a small analysis to determine which youth were the most problematic at the facility and what their lengths of stay were. Nine (9) youth were identified by administration and staff to cause the most problems at the facility with behavior, fights, aggressive activity, etc. It was determined that:

- All of the nine youths had been at the facility more than 50 days.
- Eight of the youths had been there more than 60 days.
- Six of the youth had been at the facility more than 100 days.
- Those nine youths (5% of the average population for July) were responsible for 23 seclusions (10% of the total number of seclusions) during July.

Problems with identifying youth on a pending placement status are twofold:

- Youth who have been released and returned to detention for violation of probation with no new charges.
- Youth who have failed to complete a placement or run away from a placement with no new charges.

These youth are awaiting new hearings for new placements or case dispositions; however, they have already been adjudicated for previous charges. Youth in a status of post-adjudication but who have returned to detention due to violation of probation or failing to complete their programs should be designated differently than those youth who are post-adjudicated youth awaiting initial placements. There may need to be three different designations for youth in confinement:

- Detention (Pre-adjudicated)
- Initial Pending Placement (Post-adjudicated)
- Violated Pending Disposition (Post-adjudicated)

DJS has reportedly completed a Confinement Review Study to analyze the problems and concerns dealing with detention and pending placement youths. The author of that study advised that the information will be available for review in the beginning of November.

DJS Response:

Several internal and external stakeholders are working diligently to reduce the length of stay for pre and post adjudicated youth at the BCJJC center. The Juvenile Detention Alternatives Initiative strategies are being implemented and are producing positive results. This will continue to be an ongoing effort between the Department of Juvenile Services and all external stakeholders.

Unabated Since June 30, 2004:

Abuse Incidents:

There were four (4) investigations for child abuse/neglect conducted at the facility during this quarter and according to CPS Intake for Baltimore City DSS, two were not reported to Child Protective Services.

On July 16, a youth was sexually assaulted by another youth who had forced his way into his bedroom, and his calls for help were not answered by staff for more than 20 minutes (ICAU Number 40488). Maryland State Police charged one youth with second degree sexual assault and the investigator from DJS sustained findings against two staff persons assigned to the unit. According to DSS/CPS, the incident was not reported to Child Protective Services for investigation.

On July 26, a youth was struggling with transportation officers in the lock-up area of BCJJC (ICAU Number 40771). A transportation staff struck the youth in the face with his hand and alleged the youth had spit on him. According to the investigation by the DJS/ICAU investigator, no other staff observed the youth spit on the transportation staff. Also, there is no statement from the youth about what occurred except in the nurse's report. The nurse's report also noted that abuse was alleged or identified and her examination of the youth revealed an injury to the left side of his face which was consistent with his statement of being struck in the face. According to DSS/CPS, the incident was not reported to Child Protective Services for investigation.

On August 31, this monitor submitted a special report in reference to a youth who was assaulted by several other youth at the facility when only one staff person was working on the unit. Neglect was indicated by Child Protective Services. See the Special Timely Report at: http://www.oag.state.md.us/JJMU/reports/BCJJC_Special_Timely.pdf

On August 17, this monitor received a report from Child Protective Services in Baltimore City that revealed their investigation had indicated two staff persons for physically abusing a youth during an incident on May 23, 2006.

Aggressive incidents:
Aggressive incidents of youth on youth assaults, youth on staff assaults and use of force dropped drastically from 310 last quarter to 142 this quarter. (It should be noted that DJS advised that the Incident Report Database was updated in September and the September data may not be accurate).

Use of Seclusion:
Use of seclusion has been reduced during this quarter. There were 607 seclusions the first quarter, 703 seclusions last quarter and 629 this quarter. It should also be noted that according to DJS Monthly Population Reports, the average population rose from 130 to 146 during the first and second quarters but declined again to approximately 140 this quarter.

Reported incidents of youth being placed in ***locked door seclusion for more than 8 hours*** (ICAU Incident Report Database) declined again from 47 the first quarter to 24 last quarter to 8 this quarter.

Seclusion Door Sheet Documentation:
On August 4, 2006, this monitor requested to see the door sheets that had been filed from youth placed on seclusion. The facility administrator showed this monitor two large stacks of paperwork (each approximately 18" high) that included the door sheets that he had not had time to review. It is suggested that an administrative aid be assigned to review and process seclusion door sheets and other routine facility forms to ensure accuracy and thoroughness. This monitor and the facility administrator proceeded to observe how seclusion door sheets were being utilized by staff and we responded to Unit 42 to check on the door sheets for secluded youth in that area.

- The youth was not in the room and we were advised that he was out for recreation with other youth.
- The door sheet revealed the youth had been checked appropriately from 6:00 AM to 1:50 PM but no checks had been recorded from 1:50 PM up to the present time of 5:30 PM.
- The nursing checks were completed with a checkmark and initials but no observations were recorded.
- There were no behavior problems noted on the seclusion form and no Unit Manager checks had been recorded.
- This youth had gone into seclusion at 7:00 AM on August 3 due to being an "imminent threat"; however, his recorded behavior indicated he was no longer a threat to staff or youth and he had been allowed to participate in recreation with other youth.

- An interview with the youth revealed he had been placed in seclusion because he was banging on his door, a piece of the door's hinge fell out and he was placed on seclusion for having contraband in his room. He said no staff had processed his behavior with him and he had not caused any problems while on seclusion.
- A shift manager processed with the youth and took him off of seclusion within the hour.
- The facility administrator immediately followed up with disciplinary action against staff for failing to conduct and record checks as required.

It is suggested that mental health and case managers also be required to conduct routine checks and record observations on secluded youth. This is to ensure youth safety and proper processing of youth so they can be removed from seclusion.

DJS Response:
Daily meetings have already been established to review seclusion door sheets and facility form completion.

BCJJC will be in alignment with the DJS policy regarding monitoring of youth on seclusion. However, whenever a staff member does not monitor youth in accordance with policy, an internal investigation will be conducted and if warranted, disciplinary action will be imposed. Although DJS policy does not require mental health clinicians or case managers to conduct routine checks and record observations for secluded youth, the intent of the policy is to conduct the checks and complete the recording. However, at the facility level plans are being implemented to actively engage mental health and case managers in the seclusion process.

Unabated Since June 30, 2004:
Inaccuracies in Seclusion Log:
On September 13, this monitor observed entries in the Seclusion Log and noted that on August 28, there were two entries where the date and time out were not noted for youth.

DJS Response:
Seclusion log entries are appropriately documented and are in compliance with established standards and will be monitored closely by administrators to ensure continued compliance.

Programming, Security and Negative Interaction between Groups:
There was a concern that different units and/or groups of youth in the facility were in conflict with each other during times of multi-group activity in the gym, dining hall and school. This monitor spoke with the DJS child advocate at the facility and he advised that he had also expressed concerns relating to friction and stress between particular groups. It is strongly suggested that individual youth be discouraged from participating in any negative group behavior and encouraged to participate in positive group activities – if they are not threatened by such grouping. Detention is not a committed program. Youth cannot be sanctioned as a group and/or be expected to participate or accept group behavior. The responsibility of detention is to keep youth safe and secure pending their court hearing. Post adjudicated youth who are in a pending placement status also have many different needs and should be housed and served totally separate from detention

youth. They also may not be amenable to group type activities if their needs are more individual-based.

EDUCATION:
No concerns noted for this quarter.

PROGRAMMING:
Inconsistency in Controlling Behavior of Youth:
This monitor observed youth walking very orderly, quietly and in a straight line in the hallway with their hands behind their backs. Staff advised that they were implementing the procedure to prevent youth from "flashing" gang signs and keep youth more orderly and structured. Several minutes later, this monitor observed another group of youth being escorted by staff but the youth were joking, horse playing and not maintaining any structured movement. It was discussed with the Facility Administrator that staff need to be consistent in their control of the youth. Safety of the youth is paramount and control is essential to prevent aggressive incidents.

HEALTH/MEDICAL:
Mental Health:
Hope Mental Health Services is providing care for youth at the facility. There are fourteen (14) full-time staff and one part-time psychologist working for Hope. Facility administrators and staff expressed a high degree of satisfaction with the services provided to date.

FACILITY AND MAINTENANCE:
Unabated Since June 30, 2004:
Lack of a suicide resistant barrier on the second tiers:
Suicide resistant barriers are being constructed on only three (3) of the six (6) units that require the construction.

DJS Response:
The first phase of the project is completed. The second phase was included in the FY'08 budget submission. Suicide resistant barriers have been completed on six (6) out of twelve (12) housing units.

Unabated Since June 30, 2004:
There is still no barrier between food service personnel and the youth in the serving line in the dining hall.

DJS Response:
The food service barrier is scheduled to be completed during January, 2007.

Unabated Since June 30, 2004:
The beds are still not suicide resistant and there are exposed holes for potential tie-off risks.

DJS Response:
The 144 Norix beds shall be ordered on November 13, 2006. Purchase Order #V00R7202637. Delivery is expected in April, 2007.

ADVOCACY, INVESTIGATIONS AND MONITORING:

Unabated for 30 or More Days:

Grievances:

- The DJS child advocate assigned to the facility appears to be working both proactively and reactively to address concerns of the youth in the facility. However, this monitor received only 10 Child Grievances for the months of July, August, and September.
- Grievances are not numbered and often do not identify which facility the grievance is from.

Unabated Since June 30, 2004:

Child Abuse Investigation Interagency Agreement:

A written interagency agreement has not been finalized for responding to child abuse incidents at the facility, although DJS maintains that they are working on having it completed.

DJS Response:

The agreement is taking longer to complete than we anticipated. It continues to be a work in progress with no true date of completion. As soon as it is signed, everyone will receive a copy.

Unabated Since June 30, 2004:

Inaccurate Reporting:

Several incident reports throughout the reporting period were improperly labeled or completed. A new incident report format and database were implemented in September. The Incident Report System and the Database are exceptional tools for identifying, reporting and investigating specific problems and concerns in the DJS facilities. Training is ongoing and ICAU supervision acknowledges the concern with incident reports not being filled out correctly. This office recommends data entry personnel be assigned to this facility to strictly handle the incident reports and screen them for accuracy and thoroughness.

DJS Response:

Incident reports are reviewed daily by managers to determine accuracy and thorough completion. This practice is already in place and will remain in effect. A team of designated staff by the Superintendent enters in all incident reports into the database.

Unabated for 100 or More Days:

Monitoring Escorts:

DJS policy requires that the supervisor on duty at any DJS facility escort the Juvenile Justice Monitor on his or her visit through the facility. This policy compromises the ability of the monitor to gather crucial information that may lead to the discovery of concerns that affect the safety and security of youth. It is the expression of staff interviewed, including supervisory staff members, that the perception of this policy is to inhibit staff and youth from divulging any information that might reflect poorly on DJS. Not only does this policy present the perception of impropriety but, is in addition, a violation of the Department's own standard.

DJS Response:
DJS is following a model developed by the JJMU assigned to BCJJC and the Superintendent. It was targeted as a model which would produce immediate identification and correction of issues as they were discovered. DJS maintains that this remains an opportunity for DJS' first line supervisors learn and observe through the monitor's eyes. This provides a learning opportunity for our staff to monitor in a manner similar to the JJMU monitor in an effort to self-examine our daily practices.

The **CHARLES H. HICKEY SCHOOL** is a State owned and operated detention facility that currently has two cottages that are supposed to be dedicated to detention and one cottage dedicated to pending placement. All three cottages are located behind a razor wire fenced in area. The Maryland State Department of Education provides instruction to the youths at the facility.

STAFFING:
Population:
The number of youth in detention has reportedly remained steady, averaging approximately 82 during this quarter. However, on August 2, 2006 this monitor discovered there were 94 youth at the facility according to the Night Sheets from July 31, 2006.

Unabated Since 2003:
Placement of Youth:
The numbers of post-adjudicated youth in detention waiting for placement remained consistent but rose slightly from a monthly average of 45 throughout last quarter to a monthly average of 46 throughout this quarter.

- On July 18, 2006, a youth submitted a grievance regarding his placement status. He had been at Hickey for seven (7) months and had been repeatedly advised that he was going to be placed at the Glenn Mills facility in Pennsylvania (he was reportedly accepted there on May 11, 2006), but the youth was still awaiting such action. The DJS Child Advocate contacted the facility case manager to determine why the youth had not been placed and the case manager provided excuses that staff assigned to the youth had been on "extended leave" and there were problems with scheduling and the State Coordinating Committee's (SCC) approval of the youth's out-of-state placement paperwork. The case manager further advised of a hearing that was being scheduled for the youth that he could not attend "due to another matter." On August 17, the youth was still at Hickey.
- On August 2, this monitor interviewed several youth and found that they had been in pending placement for two to three months. There were varying reasons why the youth had not been placed but there must be a constant emphasis on placement of these youth. The Night Sheets from July 31 revealed the following pending placement information:

    - There were 94 youth at the facility
    - 53 youth were identified as committed (pending placement).
    - 20 youth had been detained for longer than 60 days.
    - 5 youth had been detained longer than 100 days.
    - 1 youth had been detained for close to seven months.

The proper and timely placement of these youth is a critical and urgent concern.

DJS Response:
Since the monitor's last visit we have made changes in the review of the youths cases at the facility; the Area Directors and CRU are more involved with expediting the placement of youth as much as the process allows and significant progress in this area has been made.

Unabated for 30 or More Days
Staff Misconduct:
Several cases of misconduct are identified in the Safety and Security area of this report. There was also an incident on August 16, 2006, when this monitor observed private contractors working on a roof above the auxiliary gym area

SAFETY AND SECURITY:
Unabated Since 2002:
There has been a dramatic increase in aggressive incidents, suicidal behavior incidents and illegal contraband. According to the DJS Incident Report database, although the average monthly population has declined, the average number of assault incidents per day increased from 1.2 per day during last quarter to1.9 per day during this quarter. It must also be noted that there has been a change in the Incident Report Database format in September. According to the ICAU supervisor, some of the September incidents have not been entered due to those changes.

Assaults and Aggressive Incidents:

- On July 17, there were two group disturbances within minutes of each other that involved numerous assaults, restraints, seclusions and minor injuries during recreation. ICAU Incident Report Numbers 40496 and 40570 indicated staff controlled the disturbances quickly and efficiently. Staff supervision advised that it was extremely hot weather and youth were just venting their frustrations with the heat. This monitor was not aware of any improprieties involving staff during these altercations and it was recommended by staff supervision that the particular staff persons involved in controlling the disturbances be recognized for their actions in preventing any major injuries but there was no subsequent recognition.
- On August 2, this monitor spoke to a facility case manager about the lack of accountability for youth who commit violent acts in the facility. He felt more youth should be sent to the adult system when they assault other youth and staff at the facility and he was aware of some violent youth actually being given "good write-ups" by case managers and other staff just so they could get them moved into a placement and out of the facility.
- On July 25, this monitor observed a soft cast on the arm of one of the supervisory staff working in the gatehouse. He advised that he had hurt his arm during a restraint with a youth at the school when another staff fell on top of him. He was asked if the incident was being investigated and he advised that it was not because it was "cut and dry." He further advised that there had been several different incidents involving gang initiations throughout the facility during the past couple weeks. Follow-up inquiries with other staff and investigators failed to reveal the existence of "gang initiations" or the incident referred to by the supervisor.

- On August 22, this monitor received an e-mail from a concerned staff person at Hickey concerning the welfare of a particular youth who was being detained for a sexual assault and was reportedly diagnosed with severe psychiatric disorders and mental retardation. This monitor immediately notified Hickey administration of the concern for this youth's safety and the administrator advised that the youth was placed on a one-on-one status and they were trying to get the youth sent to a psychiatric facility. On August 28, the youth was involved in a Youth on Staff assault (ICAU Number 41617) in which staff were bitten and grabbed by their testicles.
- On September 16 at 8:00 AM, several youths were engaged in a fight in the dining area (ICAU Number 50438). The youths were restrained and removed to seclusion. The incident was reportedly videotaped. No injuries to youth or staff were noted in the incident report, although one staff person involved in the incident subsequently reported an injury to this monitor on October 10, 2006.
  - On September 16 at 5:15 PM, one of the youth's involved in the above fight and seclusion was released from his room to go to the bathroom, at which time he somehow opened the door of another youth in seclusion and a fight ensued (ICAU Number 50517). As a result of the altercation, the youth threw a milk crate at the fire alarm sprinkler system, damaging same.
  - On September 17 at 11:15 AM, the same youth as above was still in seclusion and he again set off the sprinkler in his room ICAU Number 50569).
  - ICAU report numbers 50571, 50683, 50685 and 50739 were completed through September 18 to capture information regarding the continued seclusion and threatening behavior of the same youth.
  - On September 25, the same youth above was involved in a large group disturbance, which resulted in a staff person being struck with a chair sustaining injuries to his mouth and nose (ICAU Number 50603).
  - On September 25 at 6:15 PM, the same youth smeared feces all over the inside of his seclusion cell (ICAU Number 50768).
  - On September 27 at 10:15 AM, a mental health clinician attempted to interview the youth but he refused to cooperate. The clinician left the room and when staff entered, the youth assaulted staff by striking him in the face two times. The youth was finally transferred to Western Maryland Children's Center on September 27, awaiting placement in a residential treatment center.
- In reference to the above incident (ICAU Number 50603), it was reported that several youth attacked staff in retaliation for their abuse of another youth. As a result of a supervisory review of the incident it was determined that several "staff will be held accountable for not following proper protocol." DJS and CPS are conducting an investigation into the incident.

Unabated Since 2002:

Child Abuse and Neglect Cases:

This Office was not notified of two alleged child abuse incidents during July. CPS was contacted and they advised they would be more diligent in complying with the written interagency agreement for child abuse reporting and investigation.

- On July 6, 2006, a report was submitted regarding a youth-on-youth sexual assault that occurred on June 30, 2006 (ICAU Number 40193). DJS/ICAU conducted an investigation and according to the investigative report, there was "insufficient evidence to prove or disprove that a violation of DJS policies and procedures

occurred." Also, according to the investigator's report, the Maryland State Police were contacted on June 30 but the investigator was reportedly advised by the police that, "The investigation will not be pursued any further."

- On July 12, a Youth on Staff assault (ICAU Number 40442) resulted in staff being struck in the back of his head with a metal chair. The youth alleged his actions were in retaliation for the staff grabbing him around the neck and CPS was notified for a child abuse investigation. The subsequent investigation by DJS was "unable to prove or disprove the allegation." CPS was notified of the incident and refused to investigate because reportedly there was no injury to the youth.
- On July 18, a Physical Child Abuse incident report was submitted (ICAU Number 40543) and a subsequent investigation by DJS, CPS and the Maryland State Police resulted in a sustained finding of abuse and criminal charges against the staff person. The DJS investigative report found that the staff had allegedly "punched and kicked" the youth for no apparent reason. The assault resulted in scratches and bruises that required basic first aid only.
- On July 28, 2006, a report was submitted regarding a use of force incident that had occurred but there was no mention of any injuries (ICAU Number 40858).
    - A shift commander's review of the report from July 28 revealed that the youth alleged abuse and said the staff had kicked him and scratched him with her radio.
    - A written statement from the youth, also from July 28, stated, "She then grabbed my shirt collar and pulled me out of my seat…she hit me in the eye with a walkie-talkie… she kicked me in the mouth…"
    - A nurse's report submitted on July 28 revealed that the youth alleged he was hit in the face with the walkie-talkie and choked. A medical exam revealed a swollen right eye, a laceration inside the youth's lip and reddened skin on the neck a chest area "due to alleged choking."
    - A subsequent grievance was submitted by the youth on August 3 and he alleged "nothing happened to [staff] when she smacked me in the face with the walkie-talkie and kicked me in the mouth because I called her a curse word."
    - On August 3, the DJS Child Advocate made the DJS investigator aware of the grievance; the investigator notified DSS/CPS of the allegation and began his investigation.
    - CPS ruled out any abuse and DJS did not sustain any violations against staff.

There are several concerns regarding this incident:

- The incident report in the ICAU database submitted by DJS revealed no injury to the youth when there was an injury**.**
- Neither DJS direct care staff supervision or the nurse contacted CPS for suspected abuse, although there was clearly an injury and an allegation**.**
- There were no violations noted against the above staff for failing to report accurately, timely and according to DJS Child Abuse Notification Procedures

- On August 30, 2006, CPS received a referral concerning a youth who was reportedly "pushed and choked" by a nurse at the facility. CPS and the Maryland State Police followed up with an investigation. DJS found that the staff did use unnecessary force and the State Police charged the staff with assault. CPS reportedly ruled out any abuse because the youth was uncooperative. On September 5, 2006, the same youth became involved in an altercation with staff (ICAU Number 41797) that resulted in the youth receiving an injury to his chin and required treatment at the hospital.
- On September 1, 2006, a Physical Child Abuse incident occurred (ICAU Number 41751) that resulted in a youth being punched in the face by other youth and a staff person. The assaulting staff person had to be removed from the altercation by a supervisory staff. An investigation by DJS ICAU resulted in a sustained finding against the staff person for unnecessary use of force.
- On September 5, a youth was involved in a Youth on Staff assault incident (ICAU Number 41801), which resulted in no injuries to the youth or staff. The incident was reported to CPS but it was not accepted for investigation because there were no injuries reported.
- On September 11, DSS received a report of an alleged child abuse involving a youth who was reportedly "tackled, and then dragged down the hallway" by staff after a youth on youth altercation. There was no injury reported by the nurse and DSS did not accept the report for investigation. DJS conducted a child abuse investigation (ICAU Number 50115) and reportedly the youth admitting to lying about the incident. This monitor recommended the State Police pursuing "false report" charges; however, DJS advised there were too many other issues involved in the case to proceed with charging the youth with a false report.
- On September 21, 2006, a youth was involved in a youth on youth assault after the group was let out of the van by staff due to disrespect and inappropriate behavior (ICAU Number 50501). The assaulting youth was reportedly forced to walk in leg irons when the assault occurred. The incident was reportedly recorded and this monitor contacted ICAU on September 22 to ascertain if a review of the video tape might reveal any neglect on the part of staff.

Suicide Incidents:
Suicide behaviors, attempts, gestures and ideations have increased this quarter from last quarter. There were 13 last quarter and 20 this quarter.

Unabated Since 2003:
Master Control Seclusion Log:
On September 14, this monitor observed the Seclusion Log Book in Master control. There were 74 incidents of seclusion in July and 89 in August. The area of the log indicating what staff person requested the seclusion was not completed 60 times in July and 79 times in August.

DJS Response:
The seclusion information is always covered on the Seclusion Observation Form. The staff person requesting the seclusion should be noted on the observation form.

Unabated for 90 or More Days:
Fence Alarm Failure:
Fence alarms were working properly on July 18 and July 25; however, a visit on August 16 revealed that the alarm had not been working since August 14. A check of the alarm log in the gatehouse revealed that on August 13, the log was not started until 8:00 AM and alarm checks from 12:34 PM to 12:44 PM were made visually because the computer was not working. There were no checks noted for the 2:00-10:00 PM shift on August 14 but the shift noted that the DJS Headquarters Help Desk was called at 10:00 AM. Reportedly, a phone repairman came to the facility on August 15 for other concerns and said he was aware of the alarm problem. The facility shift commander came into the gatehouse at 1:50 PM on August 16 and this monitor asked him if he was aware of the alarms being down and he said he was not. On September 14, this monitor discovered the alarm company had repaired the fence alarm just by resetting the alarm.

DJS Response:
Even according to the monitor's account, the alarm was operation in July and not working at some point in August, this is not an unabated concern for 90 or more days.

Unabated for 180 or More Days
Failure to Maintain Video Monitoring Equipment outside the Infirmary:
On July 18, a check with the video monitoring process for the satellite infirmary revealed no procedures had been put into place. The facility administration has advised the equipment will not be maintained according to any specific procedures because the equipment was installed privately and is not part of any State installed system. This Office maintains that if security equipment is being utilized there should be some procedure in place to make sure it is being used and maintained properly.

DJS Response:
The existing cameras that are in place were left on the premises by the previous contractor. The system is obsolete and not up to DJS standards and the cameras are no longer serviceable.

Vehicle Inspections:
On July 18, this monitor observed a large panel truck dropping off food to the kitchen area of the facility and the truck was being unloaded by youth at the facility. The truck subsequently exited the facility and there was no visual check made of the interior of the vehicle at the main gate to ensure there were no youths hiding inside**.**

Contraband:
Incidents of illegal contraband rose from 8 incidents last quarter to 16 this quarter.

DJS Response:
Illegal contraband rose due to the more intensive monitoring conducted by staff. Searches are conducted on each unit during each shift. The searches are being documented on Shakedown Reports by the unit staff, signed off on by the Unit Manager and reviewed by G. McDowell, Assistant Superintendent for Operations.

Access to Dangerous Chemicals:
On September 13, 2006, ICAU Incident Report 50080 revealed a youth was found with a bottle of bleach in his hand and there was a concern that he had ingested some of the

fluid. A medical examination revealed no bleach had been ingested. An investigation by the security director revealed the fluid was not bleach but it was some other cleaning fluid. He advised that the closet containing the cleaning supplies had been left unsecured and an investigation is still ongoing to determine what staff was responsible for leaving the closet unsecured.

Unsecured Doors:
On July 18, this monitor visited Ford Hall and knocked on the outer door to the infirmary in an effort to find entry into the building. A person inside advised that the door was locked and the person did not have a key. I tried the door handle and found that the door was not locked and was, in fact, partially ajar. This monitor proceeded into the infirmary and found a female staff person working. The door was pulled closed and the staff person became upset that the door had been closed because it locked and she did not have a key to let herself back out. The staff person had to contact another staff person by phone to have the door unlocked so we could exit the building. Medicines and other drugs are stored in the infirmary area of Ford Hall. Staff working in the area should have keys and access so the doors can be secured properly.

EDUCATION:
Trailers:
On September 14, 2006, this monitor observed three new trailers had been delivered for setup as additional classroom space.

PROGRAMMING:
Levels System:
The facility tries to maintain a levels system within the facility; however, programming for detention youth must keep a focus on safety and responsibility. Detention youth should also be programmed separately from pending placement youth but some detention and pending placement youth are housed and programmed on the same unit.

HEALTH/MEDICAL:
Mental Health:
Glass Mental Health is providing services at the facility. There are two mental health clinicians assigned to each unit to provide both group and individual therapy. Staff and administrators have expressed a high level of satisfaction with the providers. There is still a concern; however, that 24 hour onsite mental health services are not available for acute situations**.** There is also a concern that violent and aggressive youth are being detained and housed with youth who are not. See the above example of an out of control youth affecting the entire facility in the Aggressive Incidents section of this report (ICAU Number 50438 and subsequent reports).

FACILITY MAINTENANCE:
Unabated Sine 2003:
The outer pedestrian sally port gate was not functioning on July 18 or July 25 and the cross-arm for exiting traffic was stuck in the up position on July 18. The pedestrian sally port gate was working properly on August 2 and August 16. DJJ Detention Standards 6.9 states, “The facility shall be controlled by appropriate means to ensure that youth remain within the perimeter…”

Transportation Vehicles:
On July 25, this monitor interviewed transportation workers about the conditions of the transportation vehicles being used to transport the youth. They advised that one vehicle was in the shop for repairs, another was not being used due to ripped and torn seats and there was only one other van left – which was being used to transport the youth. There were concerns that the vehicle was "pulling to the left" when brakes were applied, the transmission was slipping and the air conditioning was not working.

DJS Response:
Vehicles are being replaced on a rotating basis. All vehicle maintenance should be taken to the appropriate repair shop or reported to Fleet Management for repairs.

ADVOCACY, INVESTIGATIONS AND MONITORING:
Unabated Since 2003:
Inaccurate/Late Reporting:
On July 6, 2006 a Use of Force incident report (ICAU Number 40194) and a Youth on Youth Sexual Assault (40193) incident report were submitted relating to both incidents that occurred on June 30, 2006. Incident Report 50501 was incomplete with numerous omissions of essential information. Incident Reports 50488 and 50490 also reveal omissions and duplication of incidents. This monitor spoke with the ICAU supervisor regarding these reports and he advised that the system was new and training for staff was ongoing to improve accuracy and thoroughness. ICAU Number 50637 failed to note any injury and was incomplete. ICAU Number 50603 failed to indicate critical information regarding a large fight with injuries to youth and staff.

Grievances:
DJS OPRA provided this monitor with three written grievances for the quarter. They were not numbered and one did not have the facility location designated. Grievances should be numbered for filing purposes and the facility should be identified. A monthly or quarterly grievance summary should be prepared to report the number and type of grievances submitted at the facility and the disposition of those grievances.

The **MARYLAND YOUTH RESIDENCE CENTER (MYRC**) is a shelter care facility for up to thirty boys, ages 12 to 18 but its residential population has decreased due to the Choice Program that uses the facility to commit youth for 7 days then works with them afterward on Home Detention. 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.

STAFFING:
Unabated for 200 or More Days:
Staff: Youth Ratios:
On July 27, the facility had 6 staffing vacancies. There is normally one direct care staff working on each unit. There should be two staff on each unit to provide security and safety. In August, a single staff intervened in a fight between two youth and as a result of one youth throwing a chair the staff received a deep laceration to his nose, which required 11 stitches to close.

Need for Male Staff:
Several staff expressed a need for more positive male staff persons who might be positive role models for the youth. Staff advised there was only one positive male role model for the youth and he is not always present in the facility.

DJS Response:
DJS will continue to recruit and hire workers under the Equal Employment Opportunity laws. Fortunately or unfortunately, we can only hire those who apply for the positions.

SAFETY AND SECURITY:
Aggressive Incidents:
The total number of aggressive incidents has decreased. There were 20 last quarter and 17 this quarter; however, the first quarter only recorded 9 aggressive incidents. Youth on youth assaults decreased from 17 to 11 while use of force incidents increased from 3 to 4. There was also one incident alleging physical abuse (currently under investigation) and one incident involving a youth on staff assault.

Unabated for 200 or More Days:
Inappropriate Placement:
In August, a youth with a sex offense history, walked off grounds and confronted a younger child. The facility administrator was able to locate the youth and convince him to return to the facility while ordering the little child to go home.

DJS Response:
Youth are placed in shelter based on the offense by the court. They have been assessed and determined to not be a threat to public safety which is why they can be sheltered.

Unabated for 200 or More Days:
AWOLs and Facility Designation:
According to the Incident Report database, some AWOL incidents are still being designated as an "Escape from a Staff Secure Facility." The facility is designated as a "shelter," youth are considered AWOLs and incidents should not be labeled as escapes.

DJS Response:
Administrative staff have been assigned to review all incident reports to ensure they are labeled correctly.

EDUCATION:
MSDE is providing education at the facility.
Some youth complained that there was no science teacher in the facility.

DJS Response:
The MYRC School is operated by DJS. A Health/Science class is included in the curriculum and will resume when the assigned teacher returns from medical leave in December.

PROGRAMMING:
Unabated Since September 30, 2003:
Van Needed:
Since DJS cannot provide the needed transportation, the facility advisory board is trying to work with the community to see if another van is available for transportation.

Unabated for 90 or More Days:
Choice Program:
The facility has been be partnering with Choice in Baltimore County and Baltimore City to provide additional programming for younger youth. The Choice program is a 7-day transitional program to help youth transition into placements. Twelve youth are supposed to be in the program at any one time but participation continues to be slight.

Population/ Choice Program:

- July 27: 22 youth in the facility and 0 youth in the Choice Program.
- August 3: 20 youth in the facility and 3 were in the Choice Program.
- August 16: 20 youth in the facility and 2 were in the Choice Program.
- September 14: 19 youth in the facility and 1 were in the Choice Program.

Recreation:
Youth reportedly attend recreation at the local YMCA every other day; however, some youth reported they had not received any outside recreation for up to five (5) days.

HEALTH/MEDICAL:
No concerns noted in this area

FACILITY MAINTENANCE:
Unabated Since 2004:
Second Floor Bathroom Repairs:
Repairs to the second floor bathroom are still pending DGS approval. One toilet was observed overflowing on September 14, paint was peeling from the bathroom wall and mildew was observed in the corners of the shower. There is a concern that mold may be forming in the wet wall space due to leakage. Reportedly, tiles are falling off the wall and striking some of the residents while they are in the shower. The DJS Asst. Secretary for Residential Services was made aware of the problem on September 14.

DJS Response
Second floor bathrooms are cleaned for mold on a regular basis. The bathroom project design was reviewed by DJS Facilities and rejected due to non-compliance with ADA requirements and sent back to the architect (CP #06-008, DGS #DH756-050-003).

Parking Lot Lighting:
Lighting is needed for the parking lot area of the facility. Undesirable persons have been seen in the parking lot area after hours.

DJS Response
A new pole and head have been ordered for the parking lot - awaiting installation. (A date for the installation can not be given at this time.)

CHILD ADVOCACY, INVESTIGATIONS AND MONITORING:
Child Advocate Visits:
On September 14, staff reported that the DJS Child Advocate had not visited the facility for more than 6 weeks. The supervisor of the child advocate unit was notified and a visit was completed the following day.

There were no grievances submitted to this office for review.

The **THOMAS O'FARRELL YOUTH CENTER (TOYC)** is an unlocked, staff-secure, privately managed residential program for male youth who are committed to the Maryland Department of Juvenile Services. The off-grounds Transitional Living Unit was closed on July 1, 2006.

STAFFING:
Population:
On August 2, 2006, there were 39 youth being housed at the TOYC facility.

Positions:
The facility administrator was on sick leave and several different staff filled in for him during this reporting period. According to a facility supervisor, as of September 25, 2006, there was only one open position for direct care staff.

DJS Response:
The Program Director's position is scheduled to be filled and as of this response was filled December 18, 2006. In addition, the Regional Director's position will be filled soon. All other positions have been filled and will be detailed in the next quarterly report.

Staff: Youth Ratios:
Staff-to-youth ratios were found to be acceptable throughout the reporting quarter.

Inappropriate Behavior:
Several youth were interviewed and there were no reports of staff acting inappropriately or disrespectful; however, on July 5, there was an investigation by DJS/ICAU regarding inappropriate staff conduct (ICAU Number 40104) that resulted in a sustained finding for inappropriate horseplay with youth and for staff making an inappropriate comment.

DJS Response:
In the above incident, the staff was found to be inappropriate and the appropriate action was taken and additional training was provided. Since that time, the staff has resigned the position.

SAFETY AND SECURITY:
Unabated Since 2003:
Aggressive Incidents:
It appears that the trend for aggressiveness and violence has remained rather steady. Incidents of youth-on-youth assaults decreased from 18 incidents last quarter to 14 incidents this quarter, and youth on staff assaults reduced from 2 last quarter to 0 this quarter. However, use of force incidents increased from 14 last quarter to 20 this quarter.

DJS Response:
In our opinion, the trend for aggressiveness and violence has not remained steady as we are making gradual process in lowering the youth on youth assaults by utilizing CBI techniques. This process challenges the youth "core issues" and leaves them vulnerable to emotions that generate various behavioral responses. We are helping these youth develop new tools to challenge irrational (entrenched) thinking patterns and ultimately change the behavior manifestations that result from these patterns of thinking.

The "use of force" may reflect our policy of reporting all incidents that involve either the escorting or separating of youths that would attempt to attack another youth. We are confident that the program's policy involving the use of force demonstrates a use of force that rarely resulted in any injury to youth. We believe all the uses of force reported during this time period were without injury to the youth.

Escape:
Two youth escaped from the facility on August 15, 2006 after jumping from a dorm window (ICAU Number 41279). One of the youth had a previous history of AWOL. The youth waited in the woods after they escaped and when police cleared from searching they broke into and stole a staff person's vehicle. A report had been submitted to DJS/OPRA; however, no investigation was initiated. On August 17, this monitor notified OPRA of the incident and made them aware of the stolen vehicle; however, no formal investigation had been completed as of September 25, 2006. An investigation by the facility resulted in staff being charged with violating performance of duty procedures and the staff person subsequently resigned his position.

DJS Response:
Efforts to address this youth's behavior resulted in double coverage since he had made two (2) previous AWOL attempts. Appropriate action was taken with staff relative to not following facility protocol. The Incident report was submitted and OPRA investigative unit screened out for non-investigation based on the report from the facility administration.

Unsecured Files for Youth:
On July 26, at 5:30 PM, this monitor visited the TOYC Transitional Living Continuum on the Springfield Hospital Grounds and found that the program had been terminated. There were no staff, youth, or other persons around and the building was unsecured. There were used logbooks, youth files, a computer and other office supplies scattered on a desk in the porch/office area of the house. The front porch was littered with broken furniture and the tailgate off of a pickup truck. All of the furniture had been moved out, with the exception of a desk on the back porch/office area. This monitor contacted the TOYC main campus and a shift commander advised that he would make the facility administrator aware of the situation. On August 2, this monitor followed up with the Facility Administrator and the shift commander that I had spoken with on July 26 and both acknowledged that the building had been secured and the youth's files removed.

DJS Response:
Please be assured that at NO TIME were log books or files exposed to the public. The material that was left behind while the program was transitioning out of the TLC house was not unsecured. Efforts were made to clean office and house and to return property to the Springfield Hospital Program. All youth files were secured previous to this date and

transported to the TOYC program. We do understand the importance of confidentiality as well as the need to protect the files on all youth.

EDUCATION:

Staffing and Training:

According to the general education director, the education department is fully staffed with seven (7) conditionally certified educators and with one certified educator. There is also a special education coordinator and a special education instructor who is still completing coursework. The director is interested in having educators attend two weeks of orientation instruction along with other teachers in the State education system. This orientation training would be in addition to what the educators receive through NAFI.

Youth interviews revealed no specific complaints regarding the education program; however, one youth stated the work was too easy at times.

PROGRAMMING:

Individual Service Plan (ISP) Review:

On August 17, this monitor reviewed an ISP and found the youth had been admitted to the facility on November 15, 2005 and ISP Reviews were not signed until a review dated June 3, 2006.

DJS Response:

The facility is following the procedures for the Individual Service Plans for youth. There was one youth admitted without the required plan and we are actively engaging case managers from DJS to present ISPs upon admission. We are also scheduling the youth's assessment seven days after admission to ensure the ISPs are completed within the ten days.

Whitewater Rafting Trip:

On August 22, the entire campus went on a whitewater rafting trip in the mountains. There were no incidents or problems reported.

Unabated Since 2003:

DJS Case Manager Visits:

According to one of the O'Farrell case managers, one youth had been at the facility for 15 months and the DJS Case Manager had not visited him since May.

DJS Response:

If Case Managers are not meeting their responsibility of visiting their youth as required, this should be reported immediately and not months later. Was this verified by looking at the youths' file? If not it is inappropriate in this report. We will certainly follow up with the youth's name.

Cognitive Behavior Therapy (CBT):

TOYC was involved with a research project that was completed through McDaniel College in Westminster, Maryland. CBT psychotherapy emphasizes how to replace thoughts that cause inappropriate behaviors with thoughts that lead to more desirable reactions. The professor at McDaniel College worked with all of the TOYC youth and staff in 10 to 12 group sessions over a period from January through the middle of July 2006 and he advised that the study had been very successful. According to the professor,

it is hoped that CBT processes and methodology will be implemented and infused into the TOYC programming and de-escalation procedures. More staff training is scheduled for October of this year.

HEALTH/MEDICAL:

Health Department Inspections:

On September 28, this monitor contacted the Carroll County Health Department to determine if there was a follow-up report for the facility health and safety inspection from May 4, 2006 that listed 72 violations, but, there was no follow-up report. The Health Department advised the inspection is completed on a yearly basis and it is expected that the items listed in the report are corrected within that time period. TOYC administrators advised that most of the items noted in the report have been corrected and there are ongoing improvements being made to the facility. However, a separate health inspection of the food service area was also conducted on May 4, 2006. That inspection listed 53 violations and the health department advised they would be conducting a follow-up in a couple of weeks.

DJS Response:

The majority of the kitchen issues involved poorly functioning kitchen equipment (walk in freezer). A special note with respect to the condition of the kitchen equipment was that all kitchen equipment for the kitchen has been determined to need replacement. Requests have been made to DJS to replace these items and three separate quotes have been provided to DJS for clearance to purchase this equipment as soon as possible.

FACILITY MAINTENANCE:

Unabated Since 2003:

Facility:

Although numerous repairs have been, or are being completed, the rear of the facility is still in need of upkeep. On August 9, a downspout was observed disconnected and lying on the ground, garbage was lying on the ground next to the dumpster, and glass had been broken out of one of the rear doors to the facility. There was a sheet of used plywood with exposed staples lying against the side of the building and another downspout was off of the front of the dorm. One of the wooden steps leading from a classroom trailer was loose. On September 15, this monitor inspected the facility with the Acting Facility Administrator at that time. The visit revealed that the grass and weeds were high and needed mowing (some of the weeds appeared to be high enough to obstruct the proper operation of outside heat pump/air conditioner units), a downspout at the front of the dorm was still missing, ceiling trim with exposed nails was hanging down from a rear porch roof, and a downspout at the rear of the dorm was cut off approximately 12 inches from the porch floor with sharp edges exposed at the bottom. Wood siding was observed disconnected and hanging down below a rear window in the dorm. Also, on September 15 we observed loose clothes, clothes hangars, storage bin lids, shoes, and a broken aquarium lying in the grass at the rear of the dorm. The dumpster area revealed a broken fan, trash, and a large empty box lying around the area.

DJS Response:

We are continuing to make repairs as soon as possible. We have contracted with a Minority Business Enterprise to provide ground and facility maintenance in order to enhance the physical appearance of the facility. In addition, we are purchasing carpeting and chairs for the school program to meet compliance standards for the Maryland State

Department of Education. The physical structure continues to deteriorate faster that we are capable of repairing it.

ADVOCACY, INVESTIGATIONS AND MONITORING:
Advocate Visits:
Administrators reported that the DJS Child Advocate has been visiting the facility on a weekly basis.
Grievance Reports:
This monitor received copies of three (3) grievances for the facility during this quarter. All involved an inappropriate attitude of a specific staff person and were resolved at the facility level.

Unabated Since 2003:
Memorandum of Understanding:
There is still no written interagency agreement between the facility, DJS, DSS, MSP and the States Attorney's Office for handling child abuse and assault incidents.

DJS Response:
Written protocols are being established. It is taking longer than anticipated.

SYKESVILLE SHELTER is a private shelter care facility licensed by DJS on State property that can house and provide services for up to 10 females. As of July 1, 2006, North American Family Institute began management of the facility.

STAFFING:
Population:
The population fluctuated between 5 and 7 youth during this monitor's visits.

Staffing:
Staff to youth ratios was found to be acceptable throughout the reporting quarter.

SAFETY AND SECURITY:
There were no significant concerns involving safety and security; however, there were several AWOL incidents reported at the facility.

Inappropriate Behavior by Staff:
Interviews with youth indicate they feel safe with staff at the facility; however, several youth advised that some staff persons "play favorites" and one particular staff had humiliated a youth and told her to "stop crying like a baby and go stand in the back" for crying and expressing her emotions.

DJS Response:
Staff are expected to treat youth with respect and caring. We expect all staff to model desired behavior.

EDUCATION:
The education provided by this facility appears to meet the needs of the youth; however, one youth advised this monitor that the education program was not challenging enough.

PROGRAMMING:
Unabated for 30 or More Days:
Off-campus Recreation:
The facility administrator advised that they were still trying to negotiate a new agreement with the local YMCA.

This monitor observed the youth participating in a "tea party" during a visit on August 17, 2006. The youth appeared engaged and interested.

Transitional Aftercare Services:
Concerns have been expressed regarding the need for transitional aftercare services for youth who have been released from a program back into the community. DJS is reportedly providing these aftercare services through the youth's field case worker and facilities no longer have that component in their contracts. Aftercare services may use the "wraparound" philosophy within an aftercare program, as was noted in the 2003 DJS "Joint Chairmen's Report" on page 10 of that report concerning pilot programs in Baltimore City and Montgomery County. The report describes the need and the ideas behind the wraparound approach and DJS should have a mechanism in place to deliver those collaborative aftercare services.

HEALTH/MEDICAL:
DJS Failure to Identify Need for Hearing Aid:
On September 15, 2006, this monitor learned that a youth was placed at the facility and during intake it was determined by Sykesville staff that the youth needed a hearing aid. The DJS intake worker was contacted and reportedly told the Sykesville Shelter Care worker that the youth was lying. A subsequent hearing test revealed that the youth did have a need for a hearing aid and apparently unbeknown to the DJS worker, the youth had a hearing aid when in a previous placement.

DJS RESPONSE:
Intake staff will be directed to contact the family of any youth who indicates they are in need of a medical appliance or they have such an appliance that should be delivered to them as soon as possible. This should eliminate additional problems in the future.

FACILITY MAINTENANCE:
Air-conditioning Failure:
On July 19, 2006, it was extremely hot and all the girls were in their rooms with fans on. The air conditioning unit had failed. On July 20, 2006, the youth were temporarily moved to the Eldersburg Library while the unit was repaired on that same day.

Unabated for 30 or More Days:
Exterior:
The exterior of the facility is in need of maintenance. Grass and weeds consistently needed mowing and there is still a large hole adjacent to the driveway just below the basketball playing area. Although the administration at the facility advised this monitor throughout the monitoring period that DJS had agreed to repair the driveway, there have been no repairs completed as of September 28, 2006.

DJS Response:
DJS Maintenance Department personnel will assess the need for repairs.

Termite/Pest Control:
On August 17, 2006, this monitor observed chemical applications taking place for termite and pest control.

ADVOCACY, INVESTIGATIONS AND MONITORING:
Grievances:
Youth and administrative staff report that youth file their grievances directly with the facility administration and were not aware of the DJS grievance person or the DJS procedure. The facility administrator was advised to contact the supervisor for the DJS Child Advocacy Unit to obtain information on what the Grievance Procedure is and how it works.

DJS Response:
We will ensure the visits to the facility are occurring as required.

Reporting and Investigations:
There is still no written interagency agreement between the facility, DJS, DSS, MSP and the States Attorney's Office for handling child abuse and assault incidents.

DJS Response:
The agreement is taking much longer to complete than anyone would have anticipated. It is still being worked on.

THE **J. DEWEESE CARTER CHILDREN'S CENTER** is a detention facility for male youth. The Department of Juvenile Services (DJS) website listed the rated capacity at twenty-seven youth. The facility operates under DJS Standards of Detention and other DJS policies and procedures.

STAFFING:
The January thru March 2006 monitoring report cited six vacant direct care positions. Staff members complained of working many hours of overtime to provide supervision of the youth. Supervisory staff members also worked overtime in to provide supervision of the youth for the facility. In May and June, the facility administration filled four of the six vacant direct care positions. The Superintendent is awaiting approval to hire two potential applicants to fill the remaining vacancies. It is unknown whether or not these two positions have been filled.

The facility also has a new Assistant Superintendent that was transferred from the Lower Eastern Shore Children's Center in June 2006. He provides administrative coverage for the facility in the evening and weekend hours and assumes the Superintendent's duties in her absence.

There is still a vacant Case Manager position to be filled.

DJS Response:

We continue to fill as many positions as we can. We have filled the following positions:

The teacher aide position was filled August 2006. As soon as the fingerprints are completed, the Resident Advisor Trainee will begin. The second position is awaiting approval to hire.

SAFETY/SECURITY:

Aggressive Incidents:

There were 12 reported incidents of Use of Force and Youth on Youth Assaults for July and August. It must also be noted that there has been a change in the Incident Report Database format in September. According to the ICAU supervisor, some of the September incidents have not been entered due to those changes.

Unabated for 30 or More Days:

Seclusions:

As reported in the April – June Timely Report, a review of the facility's Seclusion Log Book during a monitoring visit conducted on June 21, 2006 revealed incomplete recordkeeping. Since April 16, 2006 there were only 10 incidents where the date and time was noted of youth being signed out for seclusions. Included in those 115 entries were entries that had no reason for the seclusions at all. This reveals that 105 out of 115 entries in the log book were improperly completed. It was also noted that a large number of the seclusions were due to the youth refusing to go to school, or youths being disruptive in school. The reason for a large number of seclusions remains unchanged; students are apparently still using seclusion as a means of not attending school. Although there does appear to be an effort to complete the Seclusion Log more thoroughly, there are still serious violations of policies being committed. There were 74 incidents of seclusions listed in the log; however, there were no incident reports produced to document the justification for exceeding the 8 hour standard of youth in seclusion. The culture of the facility's operations, as well as the youths' attitude toward the use of seclusion, is of great need of evaluation. Seclusions have appeared to become too common a practice for non-compliance for staff, and a means of avoiding school for the youth.

DJS Response:

The logbook has been corrected and shall be maintained in a proficient and timely manner. Supervisors will maintain the logbook and the Asst. Superintendent will oversee the documentation.

EDUCATION:

Class Size:

When the population increases over the design capacity of fifteen, the teaching areas become crowded. The classes are now held in the dayroom and small dining room of the facility. DJS has stated that plans are being considered to provide two modular units for classroom space. One unit would be considered the special education classroom and the other for a general education classroom.

DJS Response:
As the monitor is aware, there are plans for a 7600 square foot unit to house three classrooms and a computer lab. MSDE, DJS capital planning and a module unit company have met. The possibility of this project taking place is ear marked for the spring of 2007.

Vacancy:
The facility has one vacant teacher's aide position. The teacher's aide provides one-to-one education to youth in need of tutoring. The teacher's aide also teaches class in the teacher's absence.

DJS Response:
The teacher aide position was filled August, 2006.

PROGRAMMING:
Unabated for 30 or More Days:
The facility does not have a structured recreation program. The facility does not have a recreation coordinator. In the January thru March 2006 and the April thru June 2006 monitoring reports, DJS stated that the Department "is looking into filling the position."

DJS Response:
A structured recreation program will be developed as soon as a recreation supervisor is hired.

During an unannounced visit the facility was having a cook-out for the youth and staff. There were speakers and entertainment by a local church youth group. The youth appeared to be very entertained and relaxed by the festivities.

HEALTH/MEDICAL:
The facility had one vacant evening shift nurse position. This was cited in every Timely Report since the January thru March 2006. DJS states that the position no longer exists. Currently one full time nurse provides medical services to the youth during the dayshift and two contractual nurses cover the weekend shifts. Facility staff members stated the facility needs an evening shift nurse to provide medical services to the youth.

FACILITY MAINTENANCE:
Unabated for 30 or More Days:
As stated in previous reports, the facility does not have a gymnasium. During inclement weather, the youth are not permitted outside and are not given strenuous physical exercise.

DJS Response:
We do agree with the monitor. No funds have been identified for the gymnasium as recommended by the monitor. Therefore, we cannot provide a completion date.

Unabated for 30 or More Days:
The facility's beds need to be replaced with a more suicide resistant model similar to the one in the Lower Eastern Shore Children's Center.

DJS Response:
The beds will be replaced or changed when funding becomes available.

ADVOCACY/INVESTIGATIONS/MONITORING:
Unabated for 30 or More Days:
DJS has stated that, beginning February 2006, the Child Advocates would no longer prepare Monthly Grievance Summary Reports. However, the JJMU respectfully requests copies of the monthly grievance summary reports that were prepared every month from November 2003 thru January 2006. The reports summarize the Child Advocate's key findings of living conditions within Cheltenham. If these reports never existed or have been destroyed, then the JJMU request confirmation of the statuses.

The new policy put in place by DJS that compels the Monitors to be escorted throughout facilities hinders monitoring visits. The Monitor must wait at the front of the facility while awaiting a supervisor to arrive and escort the Monitor. This process can sometimes take several minutes to coordinate, therefore, negating the monitor's tool of unannounced visits. In addition, staff persons are not permitted to speak to a Monitor without a supervisor present. The lack of privacy during interviews hinders inquiries and investigations into matters of concern.

DJS Response:
This procedure will remain in place until further notice, however; we are willing to revisit the decision with suggestions from the monitors on how we can improve the distribution and verification of the monitor's findings. As this is also a method for DJS to learn from the monitors.

The **LOWER EASTERN SHORE CHILDREN'S CENTER** (LESCC) is a twenty-four bed detention center owned and operated by the Department of Juvenile Services (DJS). The facility houses male and female youth. The facility operates under DJS Detention Standards and other policies and procedures. MSDE provides education at the facility.

STAFFING:
Population:
According to DJS Monthly Population Reports, LESCC averaged 25 youth in July, 25 in August and 20 in September. Observed population numbers were as follow:

- July 9: 20 males and 5 females
- July 13:18 males and 3 females.
- July 28:16 males and 5 females
- August 15: 15 males and 6 females
- September 15: 18 males and 5 females
- During each visit, youth were being properly supervised according to the DJS staffing ratio of 1:6

Unabated for 30 or More Days:
Overtime:
On July 9, 2006, staff reported they were often forced to work overtime to maintain minimum staffing levels. On July 28, staff reported there had been some improvement in staffing and they were not being forced to work as much overtime as before. On August

15, administration reported they had received 7 new staff and there were only 3 vacancies. As of September 17, staff and administration agreed that the use of overtime was not as prevalent as it was at the beginning of this quarter. The facility is anticipating the hiring of 10 to 20 new contractual positions, possibly on a part-time basis from local colleges, to address the needs of the facility.

SAFETY/SECURITY:

Incidents:

According to the DJS Incident Report database, there were 27 aggressive incidents (incidents involving assaults and use of force) during January through March. There were 40 aggressive incidents in April through June, and there were 37 aggressive incidents in July through September. The levels program may help to address some of the aggression in the facility but administration must continue to seek ways to reduce the amount of aggressive activity between "youth and youth" and "youth and staff." (See pending placement concerns and mental health concerns below).

Seclusion Use:

Seclusion was used 21 times in July, 10 times in August and 12 times in September.

Pending Placement Youth and Seclusion:

A review of the seclusion log for the month of July revealed that 11 of the 21 uses of seclusion involved youth who were on a pending placement status. Pending placement youth often become impatient and angry due to their status of waiting on what they consider "dead time;" therefore, they should be housed separately from pre-adjudicated youth to prevent altercations.

Orderly and Quiet:

On July 13 at 8:45 PM, the facility was very orderly and quiet as youth completed their showers and prepared for bed.

Seclusion Paperwork:

A July 9 visit revealed two incidents in July where staff had failed to indicate the date and time a youth was released from seclusion in the Seclusion Log Book. There were also concerns during an August 23 visit regarding the failure of staff to accurately record behavior on the youth's seclusion sheets. The facility administration addressed these concerns immediately and sent this monitor a copy of an internal memo dated August 25, 2006, holding staff accountable to fill out seclusion paperwork properly.

EDUCATION:

Education and Direct Care Staff Collaboration:

Direct care and education staff at the facility reportedly attend meetings daily. This monitor observed the education staff at the facility and they appeared very positive and motivated. However, there were some concerns relating to the direct care staff assisting teachers in the classroom. Administrators and this monitor discussed the possibility of having residential staff permanently assigned to work with the teachers, with weekends off, so there would be no disruption in the school day (due to shift change at 2:00 PM) and staff might use this opportunity to seek this position with an incentive to provide better quality services to youth. The facility administrator advised that he may be able to provide more flexibility in staffing when he fills some of his contractual positions.

Youth interviews revealed that the youth felt their education was adequate.

PROGRAMMING:
A levels system based on positive peer influence has been placed into effect by administrators at the facility.

- Barbering and Beautician Programs:
  Both of these programs started on August 14, 2006.
- Open House:
  A very successful open house for the community, staff and DJS administrators was held on August 16, 2006.
- Grandparent volunteers and Faith Based Initiatives programs are still pending.

Unabated for 30 or More Days:
Pending Placement:

- On July 9, a female youth had been on pending placement status for 151 days. Staff and the youth indicated that her family was moving to Florida and DJS was going to coordinate her transfer with the appropriate authorities. On July 28, the youth was still in the facility and the administrator advised she was being transferred in one week. On August 15 the female youth was still at the facility. Her case manager advised that she had a court date set for August 25. On September 17, this female youth was still at the facility. She had been there for 219 days in a pending placement status and she was scheduled to leave the facility and go to Florida on September 24, 2006.

DJS Response:
Please be advised that there are some situations that we cannot control and the dates that out of state facilities can accept youth is one of them.

- On July 9, two male youth had been on pending placement status for 72 and 74 days. Youth and staff said the youth were having problems being accepted into programs due to the seriousness of their charges and poor behavior. On July 28, there were two male youth who had been on pending placement for more than 50 days and three had been there more than 70 days. On August 15, there were still three male youth who had been at the facility for more than 90 days. One of the youth was reportedly still at the facility because he was not taking his medication so his case manager was not sending out his referral packets. The youth became compliant on August 10 and his packets were sent out to three different facilities. The youth had previous commitments to several mental health facilities. Contact was made with the DJS Detention Alternatives Coordinator on August 21 and there has been an increased effort to hold case managers accountable for referrals and placements. (See Mental Health below).

Pending Placement Youth and Seclusion:
A review of the seclusion log for the month of July revealed that 11 of the 21 uses of seclusion involved youth who were on a pending placement status. Pending placement youth often become impatient and angry due to their status of waiting on what they consider “dead time”; therefore, they should be housed separately from pre-adjudicated youth to prevent altercations.

Failure of Field Case Managers to Visit Youth:
An interview with one youth and staff revealed that he had been at the facility for more than 90 days and his field case manager had only visited him one time.

DJS Response:
Case manager are visiting youth at LESCC on a regular basis. This Superintendent has observed case managers at the facility on weekends supporting family visits from as far way as Baltimore City.

HEALTH/MEDICAL:
Food:
Some youth reported that the meat did not appear fully cooked sometimes.

DJS Response:
All of the meals are constantly being monitored by the Food Services Director to ensure that they are properly prepared and at the correct temperature.

Mental Health:
Although DJS reports that there are more DHMH facilities available to house DJS youth, there are many concerns regarding youth who are diagnosed with mental health problems, including that they are often being held in shelter, detention or pending placement for extended periods of time. Based on recent visits to LESCC, some of these youth appear to be very problematic for staff and it also appears that many of these youth should either be in a mental health facility (some have already been in a mental health facility) or DJS must have mental health professionals available on a 24/7 basis that have the ability to treat these youth in a medical setting set aside within the facility. When youth are placed in the medical setting of a mental health facility their behavior can be managed more aggressively with drug treatment and sanctioned restraints; however, when these same youth are placed in a detention facility, they may refuse their medications. DJS direct care staff are left to try and deal with managing their behavior and they are very vulnerable to allegations of using unnecessary force or abusive techniques.

FACILITY MAINTENANCE:
Unabated for 30 or More Days:
Toilets and Sinks:
DJS has not replaced the porcelain toilets and sinks with stainless steel models.

DJS Response:
These items remain on the agenda and as soon as a date becomes available, the monitor will be notified.

Bathroom:
On July 9, one staff bathroom was out of order.

ADVOCACY/INVESTIGATIONS/MONITORING:
Grievance Procedure:
This monitor only received one (1) grievance from DJS for this facility during this quarter; however, the DJS Child Advocate advised there were more than one grievance

submitted by youth. Youth who were interviewed stated they were familiar with the grievance procedure and they felt the process was handled fairly and quickly.

Grievances are not numbered.

DJS Response:
Grievances will be numbered beginning in October, 2006.

The **THOMAS J. S. WAXTER CHILDREN'S CENTER** is a State owned and operated detention/residential treatment facility that houses females under the age of 18. The single bed capacity is 68. The facility is comprised of one detention unit, one pending placement unit, and one secure committed program. Thomas J. S. Waxter Children's Center is operated under the Department of Juvenile Services (DJS) Standards of Detention and other DJS policies and procedures.

STAFFING:
The facility continues to be understaffed. There are a total of six (6) Direct Care positions needing to be filled, (4) Resident Advisors, (1) Shift Commander, and (1) Unit Manager. There were occasions during monitoring visits that staff members were in the middle of working a double shift. The facility administration, however, appears very cognizant in strategic planning and staff training in order to adequately service the youth. There are in-house staff trainings and weekly staff meetings; daily there are briefings with managers and department heads; and, additionally, there are formal managers' meetings conducted every Tuesday.

DJS Response:
Recruitment and hiring is ongoing for the facility. We will continue to attempt to fill vacancies as they occur.

SAFETY/SECURITY:
There were 29 aggressive type incidents that occurred during July and August of this reporting period as provided by DJS computer system. It must be noted that there has been a change in the Incident Report Database format in September. According to the ICAU supervisor, some of the September incidents have not been entered due to those changes.

Suicidal Behavior:
On July 5, 2006 a youth displayed suicidal behavior by ripping a piece of a shirt and attempting to tie the piece of shirt around the sprinkler system. A staff member was able to stop the youth before the youth could finish tying the material. The youth was then placed on suicide level II.

While on suicide level II, the youth mentioned in the above incident also attempted suicide the following day by tying a sheet around her neck. The youth was caught doing this by a staff member. No injury was sustained to the youth.

Youth on Youth Assaults:
On September 13, 2006, there was a report of one female youth sexually assaulting another female youth by using a toothbrush holder to penetrate the victim youth's vagina

while both youth were in the bathroom/shower area. The victim youth was taken to Mercy Rape Center for evaluation. There was no mention of physical injury sustained to the victim youth. According to the victim youth, the act was consensual. It was reported that the assaulting youth was placed in social segregation and the victim youth was moved to the Tour Office unit for protective custody.

There were several incidents where youth used the dining setting to act out aggressive and disruptive behaviors. Fights and youth challenging staff have taken place in the dining hall.

DJS Response:
Youth will continue to be monitored according to policy and disciplinary actions will be taken when youth are not monitored appropriately.

During this reporting period, there was a Special Timely Report completed by the JJMU. (http://www.oag.state.md.us/JJMU/reports/WaxterSpecialTimely.pdf) The report detailed allegations of excessive force used by a Waxter staff member while attempting to restrain a youth from fighting with another youth. The incident occurred on May 16, 2006; however, deficiencies were not realized by the monitoring office until August, during multi-disciplinary meeting for child abuse held at the Department of Social Services in Annapolis. The monitor's inquiry revealed an inadequate investigation by Anne Arundel County Child Protective Services, and the Maryland State Police. In addition, the Department of Juvenile Services failed to remove the accused staff member from contact with youth during the investigation as required by DJS Policy; nor did the facility notify CPS within 24 hours as mandated by Family Law, § 5-705.

EDUCATION:
According to the facility Superintendent, the position of Principal once existed; however, the position no longer exists. There is a teacher who acts in a dual role as teacher/principal. The facility would benefit in having a full-time devoted principal position.

DJS Response:
We are looking to fill the principal position. We have no date at this time.

PROGRAMMING:
As noted in the April through June Timely Report the facility has been enhancing the programming schedule by adding a Book Club and allowing more volunteer organizations to provide services to the youth. Some of the seminars and programs provided to the youth in addition to the book club have been:

- The Junior Women's League of Annapolis
- Girls Scouts of America every Monday
- Baby Day- Youth who are mothers were allowed a special visitation by their children
- Staff vs. Youth softball game and awards ceremony
- A day-long marathon of groups and speakers speaking on the topic of substance abuse was held on August 12, 2006
- September 29, 2006 a Gospel Revival is scheduled

The facility has a youth advisory board made up of two youth from each of the units. The purpose of the board is to hear the concerns of each unit as expressed by the representatives of each unit. In addition, Unit A youth (low-risk youth) were taken on outings to Russet Library.

Recreation:
The recreation program has improved. In the April – June, 2006 Timely Report it was cited that there was still a need for improvement in the recreation program. There appeared to be a lack of structure in the recreation program. This monitoring period showed improvements in the structure. Now the program encourages the youth to participate in activities such as aerobics, kickball, volleyball, basketball, weight training, and arts and crafts.

HEALTH/MEDICAL:
The facility conducts daily Initial Screening Plan meetings on new youth admissions, as required within 72 hours of the youth's transfer into the facility. In addition, the facility conducts Initial Screening Treatment Plans (ISTP) on every youth after the youth is in the facility for five days. This meeting is also conducted daily.

Unabated for More than 90 Days:
FACILITY MAINTENANCE:
As cited in each Timely Report starting with October - December 2005, the facility administration reported that five showers and four toilets will be added to the detention unit's bathroom sometime this year. Those installations have not yet occurred. The process of updating the telephones and computers has, however, begun.

DJS Response:
The bathroom expansion is still on the capital planning agenda. As soon as we learn the dates, the monitor will be notified.

ADVOCACY/INVESTIGATIONS/MONITORING:
DJS has stated that, beginning February 2006, the Child Advocates would no longer prepare Monthly Grievance Summary Reports. However, the JJMU respectfully requests copies of the monthly grievance summary reports that were prepared every month from November 2003 thru January 2006. The reports summarize the Child Advocate's key findings of living conditions within Cheltenham. If these reports never existed or have been destroyed, then the JJMU request confirmation of the statuses.

The new policy put in place by DJS that compels the Monitors to be escorted throughout facilities hinders monitoring visits. The Monitor must wait at the front of the facility while awaiting a supervisor to arrive and escort the Monitor. This process can sometimes take several minutes to coordinate, therefore, negating the monitor's tool of unannounced visits. In addition, staff persons are not permitted to speak to a Monitor without a supervisor present. The lack of privacy during interviews hinders inquiries and investigations into matters of concern.

DJS Response:
It is our desire to maintain uninterrupted schedules for the youth and protect visitors to the facilities. We are escorting all visitors throughout the facility.

The **CHELTENHAM YOUTH FACILITY'S (CYF)** maximum capacity is 110. Random review of records covering this monitoring period revealed numbers of 112, 119, 118, 120, and 123 on numerous occasions. The facility housed male youth between the ages of 12 and 18 on four detention cottages and one shelter care cottage. On May 1, 2006, DJS opened a new committed program in the shelter cottage. The Re-Direct program is a 30, 45, and 60 day program for boys. The facility operates under DJS Detention Standards, COMAR, and other policies and procedures. The United States Department of Justice also monitors the facility through a Memorandum of Understanding dated June 29, 2005.

Unabated for More than 90 Days:
STAFFING:
Vacancies:
Cheltenham has approximately thirty-five (35) vacancies:

- 20 Part-time Direct Care
- 13 Permanent Full-Time
- 2 Full-Time Contract

The facility administration continues to actively recruit new staff members and has recently filled 20 full-time direct care staff positions. The new staff could help to lower staff to youth ratios and ease the staff members having to work many hours of overtime to provide supervision during staffing shortages. The facility had ten case manager vacancies. All but two of the positions have since been filled.

It appears that the facility is making an effort to maintain proper staff/youth ratios by the use of overtime personnel. There were, however, several occasions when the ratios dropped below the standard levels. There were a couple of incidents of daytime ratios of 1:11 and 2:14, and overnight ratios of 2:19.

Appearance:
During the July 1, 2006 visit, a male staff member was wearing a black sleeveless shirt as part of his uniform. During another visit on August 25, 2006 another staff member was seen wearing a non-issued shirt. This gives the appearance of lack of professionalism.

DJS Response:
Staff will continue to be monitored to ensure they are properly attired. They will also be issued state attire.

Training:
During the last reporting quarter there was a citation where it was discovered that the documentation of trainings were being falsified. Since this revelation the facility has assigned a new training coordinator to instruct the staff. On several occasions during unannounced visits, the training coordinator was observed conducting well-organized and structured training sessions.

SAFETY/SECURITY:
Disorganization:
During the August 25, 2006 visit, the facility seemed much disorganized. Several cottage groups were moving in formation throughout the grounds of the facility simultaneously.

Due to safety and security concerns this should not occur. The on-duty shift commander attempted to gain control of the movements via two-way radio transmission; however, several staff members appeared to become argumentative during the radio communications.

DJS Response:
Administrative staff have been directed to constantly monitor the movement throughout the day to ensure organized movement.

Video Monitoring:
During visits the unit video camera in Henry Cottage was locked in the staff bathroom. In an emergency situation this could pose a challenge if the camera was needed to make a video documentation of the incident. In contrast, a staff member in the Cornish Cottage had the unit's video camera on his person during recreation time. This accessibility made immediate usage of the camera feasible.

DJS Response:
We will continue to explore the best methods for the use of the cameras without having staff holding on to them during the course of a full shift. We will make decisions on the best method before the next report becomes due.

Two of the video cameras were malfunctioning. The IT department has been notified and the facility has requested replacements.

Unabated for More than 90 Days:
Youth on Youth Assaults:
The facility had 73 youth on youth assaults during this reporting period, compared to 66 youth on youth assaults during the April - June 2006 reporting period. It must also be noted that there has been a change in the Incident Report Database format in September. According to the ICAU supervisor, some of the September incidents have not been entered due to those changes.

Fights:
On September 11, 2006 two youth were fighting in a classroom. The Direct-Care staff member had left the room prior to the fight to escort another youth out. Upon hearing the disturbance, the staff member reentered the room to break-up the fight. He was assisted by a staff member who was floating between classrooms due to a staff shortage. The concern of this Monitor is that there were apparently no Direct-Care staff members supervising the other two classrooms while assistance was being given to the fight incident. Although great effort seems to be given to adequate staff coverage by the use of overtime personnel, having to depend on this method of coverage jeopardizes safety. DJS must develop a method of streamlining the hiring process in order that new hires are integrated into the facilities as quickly as possible.

DJS Response:
We are continuing to hire staff to fill the vacant positions as quickly as possible.

AWOL:
On September 28, 2006 two youth in the shelter care program jumped out of the van transporting them to a field trip in Washington D.C. and escaped. The youth were found two days later and returned to the facility.

EDUCATION:
Staffing:
During this quarter the facility's school was assigned a principal. The new principal appears very eager to insuring a structured environment for the youths' education. In addition, a new Transition Officer has been hired to assist with youths' transitions back into their public schools upon release.

The Master School Schedule:
The schedule was revised to provide for 6 hours of instruction each day, as opposed to 5 hours of instruction provided in the old schedule. The educational program of this facility is not under MSDE, but is run in compliance with COMAR regulations reference public schools. It is reported by DJS that the credits earned while attending educational programs operated by DJS transfer to public schools.

Broken Window:
During a visit on August 25, 2006, I observed a large text book embedded in a broken classroom window. I was told that the book was thrown earlier in the day by an unruly youth. The book was not removed and the window repaired until it was pointed out by this monitor. Due to the broken glass on the window, this presented a dangerous condition for injury.

DJS Response:
Once the window was broken, facility maintenance staff was immediately notified. At the time that the monitor noted the broken window the classroom had already been sealed off and no youth had access to it. In addition the maintenance staffs were in the process of cutting the replacement plexi-glass and had replaced the broken window before the Monitor exited the facility.

PROGRAMMING:
Book Club:
In August, the facility started a book club and updated the school library. In September the facility celebrated a Hispanic Heritage month by providing various cultural information projects and serving Latin foods. Also in September youth were entertained with African dance and histories of the dances. Additionally, every fourth Wednesdays there are poetry reading sessions.

Recreation:
The recreation program appears to be very structured and orderly. Checks of the recreation log indicate that the youth are provided with at least one hour of structured large muscle group activities each day. The youth play basketball, swim, or lift weights. The Recreation Coordinator appears to be very conscientious about the youths' recreation needs, as well as being very organized and detailed.

HEALTH/MEDICAL:

Nursing:

Nursing staff complain of contract nurses showing up late for work, if at all, resulting in a shortage of staff. In addition, as sited in Timely Report April – June 2006, the nurses complain that hand soap is not provided as timely as needed.

DJS Response:

The facility recently received permission to hire three full time RN's.

The Agency has received several penalties for uncovered shifts during the summer months. Their ability to fill shifts has dramatically improved during the last 3 billing periods.

There has been an adequate supply of hand soap issued to all departments to ensure that a sufficient supply is on hand.

Contagious Condition:

A check of the Health Center log book indicated that a youth on the health center unit was removed from class for sleeping and being disruptive in class. However, the youth was reported to have had shingles at the time of the classroom incident. Due to the highly contagious nature of shingles, the youth should have been quarantined from the other youth and not been allowed to attend class with other youth.

DJS Response:

The youth the monitor is referring to had been seen by the doctor who had determined that the youth was not contagious and cleared him to be in contact with others.

FACILITY MAINTENANCE:

Cleanliness:

The holding area in the Tour Office frequently appears unsanitary. The floor is in constant need of mopping, pieces of trash were on the floor and the area had a foul smell. The utility closet in the Tour Office also had a foul smell and there were several buckets of stagnant mop water just sitting.

DJS Response:

A staff has been assigned to maintain the cleanliness of the Tour Office and the School on a routine basis.

The residential rooms appeared clean, orderly and organized.

ADVOCACY/INVESTIGATIONS/MONITORING:

Pillow Cases:

Youth complain that the new pillow cases that they were issued are very uncomfortable and they have difficulty sleeping when using them. I asked to see the pillow cases that were stocked in a supply cabinet and upon feeling them I also thought that the cases felt irritating to the skin.

DJS Response:
We have secured a different vendor to supply a better quality pillow case for the units. This issue too was already being addressed at the time of the Monitor's visit. Presently the new pillow cases have already been issued and are in use.

Unabated for More than 90 Days:
Grievance Reports:
DJS has stated that beginning February 2006 the Child Advocates would no longer prepare Monthly Grievance Summary Reports. However, the JJMU respectfully requests copies of the monthly grievance summary reports that were prepared every month from November 2003 through January 2006. The reports summarize the Child Advocate's key findings of living conditions within Cheltenham. If these reports never existed or have been destroyed, then the JJMU request confirmation of the statuses.

Monitor Escorts:
The new policy put in place by DJS that compels the Monitors to be escorted throughout facilities hinders monitoring visits. The Monitor must wait at the front of the facility while awaiting a supervisor to arrive and escort the Monitor. This process can sometimes take several minutes to coordinate, therefore, negating the monitor's tool of unannounced visits. In addition, staff persons are not permitted to speak to a Monitor without a supervisor present. The lack of privacy during interviews hinders inquiries and investigations into matters of concern.

DJS Response:
We are concerned about keeping our youth on schedule and unaffected by random visits throughout the day. We are sure that the monitors do not have a problem with keeping our youth on schedule.

GUIDE STRUCTURE SHELTER CARE is a privately operated non-secure facility located on Department of Juvenile Services' property. The license allows for a capacity of ten male youth. The vendor is held accountable for its services by Code of Maryland Regulations (COMAR) and certain DJS licensing requirements. This facility's population mainly consists of youth from Frederick County.

STAFFING:
The facility continues to have a dedicated staff with no vacancies. There are 22 current staff members, all of whom have recently received CPR/First Aid Training and Crises Intervention Training.

SAFETY/SECURITY:
Three (3) Youth on Youth altercations occurred in the facility during the reporting period. It must also be noted that there has been a change in the Incident Report Database format in September. According to the ICAU supervisor, some of the September incidents have not been entered due to those changes. One youth on youth assault resulted in a minor injury.

PROGRAMMING:
The youth continue to participate in activities in the community. The youth perform weekly Community Service hours at a local homeless shelter.

EDUCATION:
The youth receive the required 5 hours instructional training.

FACILITY MAINTENANCE:
The badly worn bathroom, kitchen, and dining room floors cited in the April thru June Timely Report have been replaced. An inspection of the side entrance porch area revealed a weak railing. With weight or force applied to the railing, the railing would give way, which can result in injury.

DJS Response:
These maintenance issues have been reported to DJS and they will be resolved as funding becomes available.

ADVOCACY/INVESTIGATIONS/MONITORING:
No issues to report at this time.

The **ALLEGANY COUNTY GIRLS GROUP HOME (ACGGH)** is located in Cumberland Maryland on property that is owned by the Department of Juvenile Services. The program is operated by the Cumberland YMCA, and serves nine female residents. The program functions as a "healthy-home" model, and relies on community resources for education, counseling, and health services. ACGGH offers a valuable treatment program for females that can be accommodated in a community setting.

STAFFING:
Director Cindy McGill is present not only during the day but frequently also during some evenings and weekends. ACGGH maintains a minimum of two staff on duty at all times. A weekend "floater" staff person is also present to provide additional security and programming options. Weekly staff meetings are held and the focus has been on group dynamics and on teambuilding. The mandatory training requirements are being met.

SAFETY AND SECURITY:
There was concern that youth might have access to caustic cleaning supplies. Those cleaning supplies are now being stored in the garage. The inside door to the garage, however, is not as secure as needed. The locks could be removed or compromised with minimum tools. This concern has been shared with the Administrator at the Group Home on a number of occasions. It is reported that a heavy duty solid door has been ordered, and will include appropriate locks.

Unabated for 30 Days or More:
The door from the basement to the garage should be replaced and securely locked.

DJS Response:
As for the garage door, there was a new door installed, and it is double locked. If a resident had tools, and was supervised she could probably get into the garage. I will ask the maintenance person to add a more secure lock.

EDUCATION:
Diane Markwood, is the Educational Coordinator for the Allegany County Girls Group Home. Most of the youth attend public schools in the area. Others work on preparing for the GED exam. Ms. Markwood coordinates with the schools and makes visits to help facilitate youths' academic success.

PROGRAMMING:
The typical length of stay is about nine months at the Allegany County Girls Group Home unless longer treatment in the residential facility is indicated. The program at ACGGH is based on a level system. Points are awarded on a daily basis for appropriate behavior in a number of areas. As the youth gain points they are eligible to advanced to the next level of privilege and responsibility. Home passes are earned by the residents to spend time with family members, and to begin the transition back to home following placement.

The residents at ACGGH receive formal individualized counseling sessions in the community. Dr. James Miller is the consulting psychologist for the home. He visits the facility two days a week to provide training to the staff and to review the treatment plans of the youth. As noted, group dynamics has been a recent focus of training. The dynamics of the group at ACGGH is a key factor in the overall functioning of the home at any given time. Group sessions are held with the girls at the facility whenever needed, and more group accountability is reportedly being incorporated into the programming. Group privileges are awarded or restrictions imposed depending on the behavior and the involvement of the group members.

The summer schedule has been varied in order to accommodate the different needs of the residents. Two of the girls have jobs. The YMCA is used often for group activities. Also the local parks are frequented for swimming and recreation activities. A day was spent at Lakemont Park in Pennsylvania. A car wash was organized and some of the girls worked at the snack shack at Rocky Gap Park. They have been permitted to use the facilities in return. The group has also volunteered to help with the Lions Club barbeque, and the club has donated $1,000 to help purchase new mattresses for the youth.

Numerous referrals have been made to ACGGH from DJS during this period. Two treatment staff members from the Group Home travel downstate whenever needed in order to interview prospective candidates for enrollment. At times it has occurred that after the interview, acceptance, and an admission date has been agreed upon, the enrollment is cancelled by DJS at the last minute without explanation. Sometimes this change in plans has happened late in the same day as the anticipated arrival of the new resident.

- Better communication between DJS and the vendor would help facilitate the kind of working relationship that is conducive to cooperative planning.

DJS Response:
DJS and Allegany Girls Group Home staff can always communicate with the Director of Gender Response Services for Girls by telephone or e-mail to resolve the issue of placements.

HEALTH AND MEDICAL:
Health and medical needs are met by community resources, and reportedly are adequately meeting the needs of youth. Evening meals are now being served family style by the staff members. Some food is stored on the floor in the pantry. This creates a problem for cleaning, and in checking for vermin.

- Additional shelving is needed in the pantry so that food is not stored on the floor. A minimum of 4 inches clearance should be provided between the floor and the lowest shelf.

DJS Response:
There is no food stored on the floor of the pantry, at this time. However, at one time, food was stored on the bottom shelf of a cupboard in the pantry. The food is now on higher shelves.

FACILITY AND MAINTENANCE:
Overall, the house is in good condition, and is well maintained by the cooperation of the Department and the YMCA. There had been a soft spot at the bottom of the stairs and that has been repaired. Another concern that has been reported previously, and noted above, is that the door leading to the garage from the basement is not secure. The garage is used for storage of cleaning materials, paint, and other substances that could be harmful to youth. A new door has reportedly been ordered. It has also been reported to this monitor that two sheds will be purchased in order to better and more securely store the potentially harmful items that are currently being stored in the garage. New file cabinets are also reportedly being purchased to replace the old cabinets, and better secure youth files.

DJS Response:
As for the garage door, there was a new door installed, and it is double locked. If a resident had tools, and was supervised she could probably get into the garage. I will ask the maintenance person to add a more secure lock.

The dressers used by the youth are in very poor condition and reportedly will soon be replaced. Currently the youth store their many personal hygiene items on top of the dressers. This is very unsightly and often the items are disorganized. There is a need for a better personal hygiene storage arrangement. There is also very limited space for the residents to hang up clothing.

The driveway to the facility is scheduled to be paved this fall.

DJS Response:
The driveway has been paved.

- New file cabinets should be purchased.

DJS Response:
File cabinets are scheduled to be purchased.

- New dressers should be purchased.

DJS Response:
Some new dressers and beds were purchased.

- A better arrangement for storage of personal hygiene items should be provided.

DJS Response:
Hygiene items have been kept on a shelf in a locked pantry; there should not be any problems with the way they are kept.

- More space for residents to hang up clothing should be provided.

DJS Response:
Additional space for residents to hang clothing is not a priority at this time. Each resident has sufficient space for her belongings.

ADVOCACY, INVESTIGATION, AND MONITORING:
The DJS Child Advocate makes regular visits to the facility, and the residents express that their concerns are heard.

The Community Advisory Board has not met on a regular basis, but a meeting was held on October 3, 2006.

Most of the Community Case Managers make visits as required, but some do not.

- All Community Case Managers must visit youth in care as required.

One youth that was enrolled in July 2006 had not received her medical card as of September 15, 2006. The Community Case Manager is charged with applying for and providing the card to the vendor.

- Medical Assistance cards must be provided in a timely manner as required.

THE DEPARTMENT OF JUVENILE SERVICES YOUTH CENTERS provide commitment care services for a total of 156 male youth, in four separate facilities: Green Ridge, provides 40 beds, and serves Area III youth in three separate programs. Savage Mountain provides 36 beds, and serves non-Area III youth. Backbone Mountain, provides 40 beds, and serves non-Area III youth. Meadow Mountain, provides 40 beds, specializes in treatment of addictions, and serves non-Area III youth.

Green Ridge Youth Center has three program components serving Area III youth exclusively. The programs include: Re-Direct, an intensive 30 day program, Revelations, a substance abuse program lasting a minimum of 120 days, and a Therapeutic Program lasting around 6 to 8 months on the average.

STAFFING:
For the most part the Youth Center staff members that had been detailed to the Western Maryland Children's Center during this reporting period have returned to the Centers. Three staff members that are recovering from injuries are still working at WMCC in the control room. The returning staff along with new hires has begun to help the Youth Centers return to better patterns of coverage. Still, because new staff members are not certified to be alone with youth, and because of training demands, vacations, sickness and family medical leave, the Youth Centers continue to struggle with minimum staffing. This not only affects safety and security but limits programming as well. The Youth Centers are "staff secure" programs, but, sometimes on second shift and on weekends, there are only 4 direct care staff members in coverage for 36 to 40 youth.

- Minimum coverage on second shift and on weekends should consist of at least one roving staff member in addition to direct group coverage.

Each Center actually needs two staff persons for each position in order to maintain adequate coverage. Long term staff members have accrued lengthy vacation time. With family medical leave, staff members can be away from work for long periods of time. Additionally Youth Center staff members are frequently called on to take youth to the Health Department for medical and clinic appointments. Combine this responsibility along with all of the reasons noted above that reduce staff on campus at any given time, and the result is that the old figure of 1.7 staff needed for each position is out of date with the reality of the situation.

DJS Response:
We will maintain the standards that we have determined for staff to student ration.

- Two staff persons should be provided for each direct care position.

- Additionally, one additional RA position should be added to each Center just to accommodate the transportation needs of the Center without leaving the campus short staffed.

DJS Response:
Funding and approval for additional positions has been requested but not been approved.

The Youth Centers have lost 18 positions over the last two years. This has happened when a staff member leaves, and his or her PIN (personal identification number) which entitles the employee to benefits, is transferred to another facility. Additionally, when a PIN has become available in the Centers due to a staff change and a Youth Center contractual staff has received the PIN, the contractual position is not replaced. The net result is the loss of one position.

- Lost positions and PINs should be returned to the Youth Centers.

DJS Response:
The Department continues to evaluate the need for adequate pin distribution. The Youth Centers continue to advocate for its need of staffing positions.

Unabated for 30 Days or More:
Even after a new staff candidate is interviewed and selected, it typically takes the Department four to six months to complete the hiring process. This concern was first reported in the 2005 April-June Quarterly Report.

Many candidates simply cannot wait this long for employment, and look elsewhere. Many other candidates have been unnecessarily ruled out because of failing the "mental health" test. The Department reports that there is an effort to speed up the processing and hiring process, and that the concern about the mental health test is being addressed.

DJS Response:
The Department has made changes to the recruitment and hiring practices that should decrease the length of time it takes from interview to hiring.

Line staff and local Administrators note that initiatives and directives often come down from DJS Headquarters Administration without any meaningful input from the staff that have been working in the programs, sometimes for years, and have a wealth of experience. There is also a very real concern about speaking up within the Department for fear of reprisal. As more and more staff members are hired as "at will" employees or are moved (promoted) from merit positions to at will positions, the message is felt to be clear, that to speak up is to jeopardize ones position.

- The Department should actively work to change this culture. DJS policies should be implemented after seeking the input from the field, including administrators, and staff that will be directly affected by the policy.

- The Department should provide safety and assurance for staff that speak up about conditions and concerns.

DJS Response:
This is the opinion of the monitor and we do not agree with this statement. Management continues to have open door policies. Staff meetings are facilitated in accordance with policy and procedures.

Staff meetings and participation on specialized committees as well as open door policies provide this forum to the staff. This commentary appears to lack factual evidence and is therefore inappropriate in this report.

SAFETY AND SECURITY:
The youth being admitted into the Centers often have histories of violence, gang involvement, and frequently exceed the behavior, IQ and/or mental health criteria by which the youth are to be screened for enrollment. More and more of these youth are being referred to the Centers. Sometimes the Youth Centers refuse a potentially dangerous or otherwise inappropriate youth many times over before being pressured or persuaded to grant a provisional enrollment. These youth are accepted on a trial basis

and moved if behavior deems that removal from the Youth Centers is indicated. Removal has generally been accommodated when requested. During this reporting period the Centers have had two incidents involving AWOL of youth who stole local vehicles in attempting to escape.

It is telling that in the year from February 2005 to February 2006 the number of youth with robbery convictions in the Youth Centers rose from 3 to 15. The number of youth with 1st degree assault rose from 1 to 5. Prior to February 2005 the Youth Centers did not admit youth that had used a gun in the commission of a crime. In February of 2006, 3 youth in the Centers had hand gun convictions. Convictions give only a part of the story. Many youth have had very serious charges and very violent histories, but the charges are pled down to lesser convictions. The only conviction listed for many youth is Violation of Probation (VOP) with no indication of the prior convictions, history, or behaviors. On July 31, 2006, 14 youth had 2nd degree assault convictions listed and 41 youth are listed as VOP. Youth with robbery convictions numbered 11, burglary numbered 9, 1st degree assault numbered 6, and 2 youth had hang gun violation convictions.

Unabated for 30 Days or More:
Youth being enrolled in the Youth Centers should not exceed the stated guidelines for admission. This concern was first raised in the 2004 April-June Quarterly Report.

A DJS Headquarters Administrator told the Youth Center staff and Advisory Board members at the last Board meeting that if the Centers did not admit youth with the histories noted above, there would be no need for the Centers. It was explained that youth with lesser offences that might previously have been sent to the Youth Centers are now being sent home on electronic monitoring and/or to receive community based services.

There is a back up of youth waiting to be assigned a bed in the Youth Centers. As a result the Centers have been under pressure to release youth at the earliest possible time that they "feel comfortable" with their progress. Feeling comfortable with progress is a beginning step in being ready for release. Many youth have a "honeymoon" period of two to six months before their underlying problems surface to be addressed. Without time and programming to facilitate a fundamental change in belief patterns and some significant healing of emotional trauma, youth often "behave" their way through the program without making the meaningful changes that will facilitate long term success. To focus on time rather than maximum treatment gain sends the wrong message to youth and to staff.

DJS Response:
Youth Center admissions are based on the present adjudicated charge and not all of the charges the youth has acquired during his history with the Department (or non plea bargained charges). The Youth Centers frequently receive youth who have violated the probation they were originally assigned; therefore, the charge referring them to the Youth Center is, indeed, a violation of probation charge. Mr. Snyder's concern about violent, aggressive youth is a shared one; however, it is getting more and more difficult to refuse a youth because of aggressive tendencies; especially, if he had not been adjudicated on the more violent offense. The Intake officer continues to reject many youth and there is

an appeal system in place that is being used by field personnel to ask that a rejected youth be reconsidered.

The Youth Centers did not admit youth with handgun convictions" prior to February 2005," as stated. In reality the Youth Centers did not admit youth who used a hand gun in the commission of a crime.

Educationally as well it is unwise to release youth by the criteria of "feeling comfortable" with their progress. Youth that are scheduled to take the GED test, for example, must stay at the Centers to complete the preparation and the taking of the test. Youth that leave before taking the GED vary rarely have the support needed in the community to take the exam. For most youth admitted into the Centers a treatment time of at least 9 to 12 months is more realistic in order to have a reasonable expectation of success upon release.

- Youth should be permitted and required to maximize their treatment and educational gains while in the Youth Centers.

- It is essential that in addition to completing the treatment/educational program, at the Youth Centers, that youth have a very comprehensive aftercare plan in place that will begin immediately upon release. This unfortunately does not always happen, especially if the youth is 18 years old. The effectiveness of treatment in the Youth Centers and the DJS system as a whole is ultimately determined by the success of the youth upon release. Unfortunately many or most youth simply matriculate into the adult system.

Incidents as reported in the DJS incident data base.

NOTE: The Electronic Incident Data Base has not been accessible by the monitors since early September 2006, and as of this writing. The numbers for this reporting period could be misleading as complete information is not available to the Juvenile Justice Monitoring Unit.

	April/June 05	Y on Y	Y on S	U of F	Injury	Del/Crim Act-other	Total
Green Ridge		1			1		2
Savage Mt.				2	2		4
Meadow Mt.				1	3		4
Backbone Mt.		1		4			5
	Total	2		7	6		**15**
	July/Sept. 05	Y on Y	Y on S	U of F	Injury	Del/Crim Act-other	Total
Green Ridge		1		3	1	1	6

Savage Mt.		2		1	1		4
Meadow Mt.		3		5			8
Backbone Mt.		3		3	1		7
	Total	9		12	3	1	**25**
	Oct./Dec. 05	Y on Y	Y on S	U of F	Injury	Del/Crim Act-other	Total
Green Ridge		4		2	4	1	11
Savage Mt.		2		2	1		5
Meadow Mt.				3	3	1	7
Backbone Mt.		1	2	5	3	1 (Escape)	12
	Total	7	2	12	11	3	**35**
	Jan./March 06	Y on Y	Y on S	U of F	Injury	Del/Crim Act-other	Total
Green Ridge		7		2	1	2 (1-Escape)	12
Savage Mt.		3		1			4
Meadow Mt.		8		1	3		12
Backbone Mt.		8	2	19	3	1 Escape	33
	Total	26	2	23	7	3	**61**
	April/June 06	Youth on Youth	Youth on Staff	Use of Force	Injury	Delinquent/Crim Act-other	
Green Ridge		4	1	2	2		9
Savage Mt.		2	2	1	0		5
Meadow Mt.		5	0	0	2	1	8
Backbone Mt.		5	0	3	4	Group Disturbance 1	12
	Total						**34**
	July/September 06 (incomplete)	Youth on Youth	Youth on Staff	Use of Force	Injury	Other	
Green		4			2	Escape 1	7

Ridge							
Savage Mt.		4		2			6
Meadow Mt.		2		3	1	Escape 1	**7**
Backbone Mt.		1	1	2	1		5
	Totals for the quarter are unknown.						

Key: Y on Y (Youth on Youth Assault) Y on S (Youth on Staff Assault) U of F (Use of Force)
Del/Crim Act (Delinquent or Criminal Act) Injury (Accidental Injury)

EDUCATION:

Unabated for 30 Days or More:

It is unclear as to what specific regulations apply to the Youth Centers Educational Program. This issue was first noted in the October-December Quarterly Report of 2003. The Centers appear to function much like a Public Alternative Education Program. However, the Maryland State Department of Education has not promulgated regulation that applies directly to the Department of Juvenile Services Educational Programs. The DJS Director of Education has stated that DJS is not a Local Educational Authority (LEA). When reporting to MSDE however, the Centers are listed under the heading Special Placement Schools (LEA: 24) Youth Centers/DJS (ID: 0103).

The confusion is problematic in that it is unclear what educational requirements and what calendar schedule the Educators at the Centers should follow. The Youth Centers enroll youth throughout the year, and the teachers were, and are compensated for working in a twelve month program. In the past, before 2003, the teachers had the same time off allotment as other employees in the Centers. School was open for youth on all days except state holidays and weekends. Additionally, one day each month was dedicated to a teacher's meeting. School was open for approximately 237 days a year. Though the Youth Center schools had a long standing record of effectiveness and close working relationship with the treatment staff, in the spring of 2003 the school schedule was abruptly changed. Wednesday afternoon classes were cancelled and 4 weeks of "professional development" days were instituted. These professional days typically coincided with holidays resulting in extended periods of the schools being closed. Some adjustment has been made and the new 2006 calendar does provide for 220 days of instruction. Also, instead of school being closed every Wednesday afternoon the school is now closed every other Wednesday afternoon.

Many, if not most of the youth are behind in their educational work, and in need of remediation, and/or special education services. With the much increased paperwork including Individualized Education Plans (IEP) that has accompanied the taking of more challenged youth the teachers say that additional time is needed to complete the reporting tasks. There is disagreement amongst the teachers about the need for the number of professional days that school is closed.

Youth interviewed do express that they receive a lot of help from school and are typically very proud of their educational gains, which reportedly average 3 months at the Youth Centers for every month that would be gained in public school. The majority of the teachers at the Youth Centers are very dedicated in their work. The GED program is very successful in the Centers with the majority of youth that take the test successfully passing the exam. The Centers do not always celebrate youths' passing of the GED with a graduation ceremony. As this accomplishment is very significant for the youth and also provides a good model for other youth, an organized ceremony and celebration would be very beneficial.

While most of the teachers and treatment staff strive to continue to work cooperatively together the changes noted above, and the process by which they have been implemented has been disruptive. Instead of working as one unified treatment/education program there is a sense of separation, and competing needs and agendas. Based on this monitor's interviews with treatment and educational staff members, this has engendered some frustration and resentment. Treatment and education of youth with emotional, behavioral, and learning problems should be mutually facilitated. It is very important that the educational staff and treatment staff work as an integrated whole in the Centers. There is much work to do in order to bring these two aspects of treatment together.

- The newly stated DJS educational goal is to provide 6 hours of education to the youth in the Centers for each day that the school is open. This will be a challenge to accomplish in order to incorporate the overriding need to provide youth with effective treatment intervention in addictions and mental health counseling, and without overwhelming the resources at the Centers. Youth must not be denied services, but reportedly staff members have been told that youth are not to be pulled out of school for any reason. This includes addiction counseling, mental health counseling, a Community Case Manager visit, or nursing. Again, it is very unclear what regulation authority is specific to the implementation of the already in-acted and the proposed changes.

There has been some preliminary discussion in exploring ways in which youth can receive credit hours for alternative and career oriented training. Training with the cooks, with maintenance personnel, and with service learning activities could be included in the hours of education. There has been a great need for youth leaving the Youth Centers that are not returning to school to have some practical vocational training and job placement program in place to help facilitate success upon release. Dr. Meisel, DJS Director of Education, has indicated that an additional teacher could be provided at each Center that would act also as a career counselor to help coordinate educational/career training opportunities. Also, a guidance counselor position has been filled.

- One of the Centers has a certified physical education instructor, but the other three Centers do not. With the provision of certified physical education instructors in each Center, youth could also receive a credit for physical education.

The DJS Youth Centers in cooperation with Garrett County Community College has implemented a Learning Opportunities Partnership designed to enable 10 eligible youth to obtain their GED and begin a college course curriculum. Backbone Mountain Youth Center is the site of the program. Ten youth have been selected to form the college preparation group, called the Honor Academy, at Backbone Mountain Youth Center. The first trial semester is just getting underway and will be evaluated for effectiveness. For

youth successfully completing the program additional funding may be able to be provided to help the youth pursue higher education upon release from the Youth Centers.

DJS Response:
There need be no confusion with regard to the educational requirements or calendar for DJS schools, including the Youth Centers. There may be some misunderstanding about the Superintendent of Education's statement in a meeting a few months ago with the Monitors that DJS schools do not constitute a separate LEA. The federal *Individuals with Disabilities Education Act* (IDEA) applies to eligible youth in juvenile facilities. Therefore, as we discussed in the recent meeting, with regard to regulations governing special education services, DJS schools including the Youth Centers are obligated to follow and in fact, do fully implement, the IDEA and the same State regulations that implement the IDEA and that govern the provision of special education services in all Maryland LEAs. An MSDE administrative designation for DJS schools for State testing purposes should not be interpreted as contrary to these requirements. The Superintendent of Education also explained that juvenile facility schools nationally, including DJS schools, are comparable to alternative public education programs in some respects such as class size and student: teacher ratio.

The monitors were provided a copy of the DJS 2006-2007 school calendar. As identified in the calendar and indicated in the monitoring report, all DJS schools including the Youth Centers provide 220 days of instruction annually. This is the same total number of annual instructional days provided in the school programs currently operated by MSDE at three DJS facilities, and is consistent with State requirements for 12-month school programs.

We concur with the Monitor that earning the GED, which is recognized in Maryland as a high school diploma, is a great accomplishment deserving of special recognition. To that end, the Youth Centers consistently recognize graduating students through a variety of activities and events. Each of these students receives graduation announcements to send to their families, as do students in local public school systems. A picture is taken of the students in cap, gown and tassel. The students keep the tassel, and the pictures are either taken home by students or forwarded to the student and family. Diplomas complete with high quality covers, are provided to all graduating students. Celebrations are held to honor each graduate who is in residence when passing GED scores are received by the Youth Centers. Youth Center staff is informed of all students receiving high school diplomas in various ways including announcements in the monthly newsletter published by each Youth Center. Case managers are notified via letter which they may also provide to the juvenile court.

An achievement celebration was held at Garrett College to recognize ten students who participated in the DJS/Garrett College Learning Opportunities Partnership. The President of Garrett College and Secretary of DJS participated in the ceremony, and each student received a Proclamation from the Governor. We anticipate this event will be held twice yearly for all students successfully completing the high school diploma and college courses through our partnership with Garrett College.

The Educational Services Unit appreciates the monitor's many positive comments about the education programs provided at the Youth Centers. We agree with the monitor that youth are best served when facility staff including education personnel work

collaboratively, and will continue to support that model. We would welcome the opportunity for continued dialogue with the Monitor on issues concerning regulations for the Youth Center education programs.

PROGRAMMING:

Programming has been affected by several factors. Basic supervision has to take priority due to the more challenged and challenging youth being admitted. Though staffing is slowly improving, lack of staffing has continued to be the most crucial factor affecting programming capability. Staff members simply cannot devote the individualized time needed when alone in coverage. One or two youth often require much of the staff member's time and as a result the less demanding youth often do not receive the treatment attention needed. Because of the increased presence of gang members in the Centers and potential for rival gang conflicts, there is more emphasis being placed on staff receiving gang identification and intervention training. Each Center has a "gang liaison" person designated. As noted, the Youth Centers are "staff secure" programs, with no fences to contain youth, and no continuum of care capability.

- The lack of a continuum of care limits resources available to provide treatment from more restrictive to less restrictive environments depending on the need of the youth.

DJS Response:

The feasibility of developing a continuum of care within the Youth Centers has been explored. It would result in some benefits as well as some detriments. It would result in a need for increased funding.

- The transportation policy requires two vans and four staff to take a group off grounds. With the limited staffing and the limited number of vans, these off grounds trips often cannot take place. This concern was first noted in the July-September Quarterly Report of 2005. In spite of obstacles, however, the Youth Center staff members do much to continue creative recreational and experiential treatment/educational programming, both on and off grounds. This is a credit to the dedication and creativity of the Youth Center staff members.

It is reported that each Center is slated to receive one new 12 passenger van sometime this fall. The Center will then and turn-in an old van. This will not resolve the transportation concern especially in providing off grounds activities to an entire group of 10 to 12 youth. The Centers do not have a vehicle such as a small bus that could serve to transport an entire group and staff off grounds.

DJS Response:

We have made the request for additional vans to the appropriate department and we will provide the monitor with an update during the next quarterly report.

- There is now a line item in the budget for recreation, and this is a beginning. Adequate funding of recreation/treatment is very important to the overall programming capability of the Youth Centers and is a vital aspect of youth's treatment and recovery.

- The Ropes/Reflections Program is now being staffed by a newly trained instructor. This is a very positive step as the program is a very valuable treatment tool.

The Program was staffed by two full-time personnel at one time, but one of the positions was moved to direct care. If fully staffed with two persons the Ropes/Reflections program would have the capability of providing valuable experiential services to Youth Center youth, and also serve many other youth as an early intervention and prevention experience. Staff members from the other Youth Centers, who were certified, in the past have assisted with their groups in the Ropes program. The new instructor will be able to re-certify Center staff so that all of the elements at the various Center campuses can be fully utilized.

Family involvement is very important aspect of affecting positive treatment outcomes. Green Ridge Youth Center arranges home visits for Area III youth placed in the 9 month Therapeutic Group program. When a youth nears the end of his treatment, and has earned a visit, and if successful, may go on a longer home visit. This programming has been positive overall. Youth who were interviewed expressed a lot of enthusiasm for the family visitation and perceived it as a valuable incentive to complete the program successfully. On September 15, Green Ridge hosted a Family Day at Rocky Gap Park. The day was reported to be very successful. Almost all of the youth had parents and/or family members present.

The other Centers have not implemented home visits as of yet, but the possibility is being considered upon evaluation and outcomes of the Green Ridge visitation policy. Backbone Mountain is reportedly planning a family day for each of the 4 groups on separate days. The youth at all of the Centers do make phone calls, and families may visit the Center.

- The Youth Centers do not have the capability of interactive video or even computer interactive programming as a resource for youth/family interaction.

HEALTH/MEDICAL:

The DJS Youth Centers contract with the Allegheny Health Department for health services. Nurses make weekly rounds to the Centers. Youth are seen as needed. Youth that need more urgent care are either seen at the Health Department or referred to the local emergency room. Each Center has a copy of the Allegheny County Health Department First Aid Manual, and medical supplies are ordered through the Health Department and picked up at the clinic.

FACILITY MAINTENANCE:

Unabated for 30 Days or More:

The National Safety Board has found all 15 passenger vans to be unsafe. Each Center used to have 4 vans, most of which were 15 passenger but they lost a number of vans to other DJS facilities by request of DJS Headquarters. This concern was first noted in the July-September Quarterly Report of 2005. All of the replacement vans will be twelve passenger vans. Each Center will reportedly be receiving a new 12 passenger van, and the Transportation Office will receive 2 new 12 passenger vans sometime this fall. Each Center is in need of 4 vans in order to accommodate the various programming needs, and in order to have emergency transportation if required.

- There is a need for a small 18-20 passenger bus that all of the Centers could share and that would be large enough to transport a group of 12 youth, teachers, and staff for outings and activities.

- The old vans were not equipped with audio and video recording equipment. This lack of monitoring equipment presents vulnerability to youth and to staff. Transportation vans should be equipped with audio/video recording equipment.

DJS Response:
Request for additional transportation have been made. As soon as we receive a response to the request, the monitor will be notified.

ADVOCACY/INVESTIGATIONS/MONITORING:
The Child Advocate makes weekly rounds to each Center unless on vacation, in training or on sick leave. An Office of Professional Responsibility and Accountability Investigator is assigned to the Youth Centers and responds as needed.

It was announced at a DJS Superintendent's meeting on June 29, 2006 that the Department was initiating a new policy with regard to the Office of the Attorney General Juvenile Justice Monitoring Unit. The new policy requires that the supervisor on duty at any DJS facility escort the monitor on his or her visit through the facility. Further it was stated that the monitor was not to interview a staff member without the supervisor present, and that youth were to be interviewed with the supervisor nearby. This policy compromises the ability of the monitor to gather crucial information that may lead to the discovery of concerns that affect the safety and security of youth. It is the expression of staff interviewed, including supervisory staff members that the perception of this policy is to inhibit staff and youth from divulging any information that might reflect negatively on DJS. Not only does this policy present the perception of impropriety but, is in addition, a violation of the Department's own standard.

DJS Detention Standard 7.3.2 Access to information: The Department shall ensure that internal and independent monitors and auditors are afforded the broadest possible access, relevant to their particular function and consistent with notions of privacy, to all appropriate information, records, data, and to staff and youth of the facility that is being monitored.

DJS Response:
We are willing to revisit this procedure with suggestions from the monitors on how we can improve communication and verification of the monitor's findings. As this was a method for DJS staff to learn from the monitor. At no time has a monitor been denied access to youth or staff.

STANDARDS:
Unabated for 30 Days or More:
Commitment Care Standards are not provided for DJS commitment care programs as of yet. This concern was first noted in the April-June Quarterly Report of 2004. Youth Centers currently operate under a procedural manual and Secretary Directives. The Youth Centers have recently completed Performance Based Standards (PBS), a self reporting process. Also, a newly developed Quality Assurance tool has been developed which will

be used to measure compliance in the Centers. The Youth Centers Procedural Manual is being updated.

THE ALFRED D. NOYES CHILDREN'S CENTER (NOYES) is a State owned and operated detention facility located in Montgomery County. Noyes houses both male and female juveniles and is designed to accommodate a total of 58 youth.

STAFFING:
While lack of staffing still is a concern there continues to be considerable effort made to improve the staffing levels at Noyes, and some progress has been made. The Department has implemented salary adjustments to help attract and retain employees working in the facility as it is located in Montgomery County where the cost of living is higher then elsewhere. Also, the Department is helping Noyes facilitate the interviewing and processing of applicants in order to bring new employees into the facility more quickly.

Unabated for 30 Days or More:
Many potential employees have been ruled out. In one hiring effort made in July, 17 of 25 applicants were ruled out. Many applicants fail the mental health test for reasons that seem very questionable. The Department reports that it is reviewing the mental health testing procedure.

Another issue affecting employees is the number of PINs allocated to the facility. A PIN assignment gives the employee full benefits. Noyes reportedly has a lower percentage of PINs than other facilities, and this impacts hiring and retention.

The overall allocation of Residential Advisor positions is low. The facility needs about 60 positions to provide consistent coverage. Staff training, which requires 40 hours a year, vacations, sickness/injury, family medical leave, and last minute call outs all contribute to diminish the number of staff on duty, and the need for forced overtime. In reality the facility needs a two to one staff/position ratio.

A new 10 hour 4 day work week has been initiated at Noyes. Although considerable overtime is still necessitated to maintain staffing levels, staff members do get a three day rest. First shift is from 7:00 AM to 5:00 PM. Second shift is from 2:00 PM to 12:00 AM, and third shift is from 10:00 PM to 8:00 AM. This creates some overlapping in coverage which presents time each week to devote to team meetings. The focus in the team meetings has been on promoting professionalism, developing a therapeutic environment, and training in policy and procedures.

As mentioned the staffing levels have continued to improve, and each unit, except the girls unit which typically houses much fewer residents, is double staffed most of the time. (See graph below) While this is a significant improvement, it has to be noted that it is at the expense of staff working many hours of overtime. In August on the 1st shift from 7:00 AM to 5:00 PM the staff member(s) were working overtime 45% of the time in order to maintain double coverage. On 2nd shift from 2:00 PM to 12:00 AM staff members were working overtime 25% of the time, and on 3rd shift from 10:00 PM to 8:00 AM 11% of the time the staff member was working overtime. This can lead to staff exhaustion and burnout. The new 4 day schedule is reportedly helping, and there have been fewer staff "call outs".

Month	1st shift		2nd shift	
January 2006	Single staff 48%	Double staff 52%	Single staff 66%	Double staff 33%
March 2006	23%	77%	23%	77%
May/June 2006	19%	81%	27%	73%
August 2006	2%	98%	6%	94%

Two additional Case Managers have been added at Noyes to help deliver services to youth.

Unabated for 30 Days or More:
Two additional Residential Group Life Managers are needed.

Unabated for 30 Days or More:
Two full time Recreational Specialists are needed to help ensure that youth receive the recreation they need and that which is outlined in the DJS Detention Standard noted below.

Unabated for 30 Days or More:
The Department asserts that one Addiction Counselor position is sufficient to provide services to the youth. It is the perception of this monitor that at least one additional counselor is needed. This is especially true when the facility is over populated.

The Psychologist Dr. Mason has left Noyes. A replacement to fill the vacancy is being sought. It is reported that at present Noyes is transferring youth that need the clinical services that had been provided by Dr. Mason. In addition to a Psychologist, an assistant position is needed to help ensure that clinical services can be provided. It is reported that a contract with a behavioral health provider may be sought to provide clinical services to youth.

The new system of assigning staff to different roles on the unit seems to be helping with supervision. When two staff are on a unit they are designated as "A" staff or "B" staff. Staff "A" is primarily responsible for security, and staff "B" is directed to focus on interaction with the youth. In conjunction with this staff assignment pattern, there has been more emphasis placed on developing a therapeutic/relational environment between staff and youth. Also, when there is an incident, staff members are reviewing the incident to determine how situations could have been diffused or handled in a better way. Additionally when there is an incident staff are processing the conflict with youth when the time is appropriate to help diffuse future incidents.

DJS Response:
The Department continues to make changes to decrease the length of time it takes to process new employees as well as the hiring of new staff. We have seen positive results from these efforts and we will continue to do so until all positions are filled.

Unabated for 30 Days or More:
At times policy and procedure has been implemented inconsistently from staff to staff. The staff meetings being held should help address this concern. It is reported that a comprehensive policy and procedural manual will be developed.

DJS Response:
All staff are required to follow the appropriate application of policy and procedure and if they do not, the appropriate actions are applied.

Noyes previously had a full time maintenance person, but that employee has been moved to Hickey and only attends to Noyes on a periodic basis. Noyes is in need of a full time maintenance person. As of this monitor's visit on August 1 there were 25 outstanding maintenance orders.

The staffing issues affecting Noyes have been reported consistently in the Quarterly Reports beginning with the January-March 2004 Report.

DJS Response:
All of the maintenance issues have been submitted to the maintenance department for resolution. As they have been moving expeditiously, we expect to have completion dates by the next quarterly report.

SAFETY AND SECURITY:
Facility inadequacies in particular present a threat to safety and security.

Unabated for 30 Days or More:
Safety and security at Noyes is severely hampered by the lack of fencing security, and lack of monitoring equipment both outside and inside the facility. The fence is obviously vulnerable to being cut from the outside.

- Sensors, lighting, cameras, monitors, and recording equipment is lacking and badly needed to enhance the outdoor security of the facility. It is been reported that youth who have been at Noyes, and/or others, have been coming up to the sleeping room windows at night and interacting with the youth inside the facility.

- The front door and windows are not tinted, and there is no announce box at the entrance.

- The interior of Noyes is not equipped with cameras, monitors and recording equipment. This greatly affects the safety and security of youth and of staff. Though handheld video cameras are available to use, this is impractical, and inadequate to ensure the necessary protection and documentation.

Fencing, recording and monitoring concerns have been reported since the July-September 2005 Quarterly Report.

DJS Response:
All of the maintenance and IT issues have been submitted to appropriate the Directors for resolution and as soon as funding is made available dates will scheduled and the monitors will be given the completion dates.

This was a budget request that was cut out of the DJS proposed budget.

- Fire drills have not been held as required. No documentation could be found that fire drills were held between April 5 and September 7, 2006.

DJS Response:
Fire drills are occurring as required. The system was in need of repair and once the system was repaired, the facility was able to resume the drills.

In June the number of incidents declined considerably. However, the number of incidents has increased again in July and August to high numbers of youth on youth assaults. In July there were 22 youth on youth assaults and in August there were 19 such assaults. This is also while the population has continued to decline somewhat. There has been considerable effort by the Confinement Review Unit to expedite placement for youth in detention.

Unfortunately the DJS incident data base is not accessible by the Juvenile Justice Monitors when the timely report was issued in October and since September 5, 2006. The database is undergoing renovation. The figures reflected below in July and August of the current quarter were gathered from the database before this monitor could no longer access the information.

Incidents:

Month	Y on Y ASLT/Riot	Y on S ASLT	CHAB	UOF	TOTALS	Avg. # of Incidents Per Day
			Child Abuse			
January 2006	12	2	2	2	18	0.58
February 2006	14	1	Possession of Contraband 1	5	21	0.75
March 28, 2006	15		4	4	23	0.74
Quarter Totals	**41**	3		11	**62**	**0.69**
April	16 + 1 Group Disturbance + 1 escape 18	3	Contraband 3 - Staff Child Abuse 1 - 4	12	37	1.23
May	20 + 1 Escape	1	Del/Cri mast by youth – 1, Staff Child Abuse – 1, Suicide Ideation – 1 3	7	32	1.03
June	12	0	Contraband – 1, Suicide Ideation – 3, Suicide Attempt - 1 5	3	20	.66
Quarter Totals	**51**	4	12	22	**89**	**.97**
July	22 + one group disturbance	2	1		26	0.83
August	19		4		23	0.74
2 month totals	**42**	2	5		**49**	**0.79**

EDUCATION:

The classes that this monitor has observed have been somewhat better in that about half of the youth seem to be at least somewhat engaged in the learning process. This represents a considerable improvement. The school trailers have been refurbished, and the units are now being split up with half going to the trailers and half receiving classes on the unit. This has served to reduce the class size and enhances participation.

- Some youth complain that the curriculum repeats frequently and does not interest them or meet their academic level.

- There is also a need to provide post GED youth with appropriate and interesting learning opportunities.

- There needs to be a special process developed for youth that refuse to participate in education or disrupt the learning process for others. One idea that is in the conceptual stage of development is to provide a Behavioral Alternative Classroom (BAC) whereby youth must complete assignments to be upgraded and released from the BAC.

DJS Response:
The educational curriculum meets the MSDE requirements.
This is the opinion of the monitor.

PROGRAMMING:
Unabated for 30 Days or More:
There continues to be excessive "down time" according to youth, staff and also upon this monitors observations. Youth are frequently kept in the day room watching, television, playing cards or dominoes, sleeping, or acting out due to boredom and lack of structured activities. The problem is made worse, as mentioned above, by the presence of youth that are members of different gangs. Some of the incidents have been gang related. When there are ample recreation activities provided the incidents tend to diminish. Having outside volunteers come in to help with activities could greatly add to the overall programming. Activities could be provided such as art, music, reading, story telling or drama, etc.

The concern about excessive down time has been consistently reported since appearing in the July-September 2005 Quarterly Report.

The three-level program that assigns points and gives some added privileges as youth gain points is inadequate. The level III activities have also been limited due to staffing. Some cookouts on Wednesdays in the afternoon, and other special activities have reportedly taken place. Administration at Noyes would like to implement the programming that is described in the Residential Child Care Project from the Family Life Development Center, College of Human Ecology Cornell University. This should greatly enhance the programming offered at Noyes.

Recreational programming has been inconsistent. Youth and staff report that outdoor recreation has been infrequent, and that even basic indoor recreation does not always take place as required. Recently the Residential Advisor that usually coordinated recreation and Level III activities has been able to be relieved from direct care duties to begin to reinstate the required recreational activities. There is a need for another staff person to be hired and who would responsible for recreation on a full time basis.

Noyes often receives youth that have adult charges and have been waived down by the court, or are awaiting a waiver hearing. These youth are typically more hardened, resistant, and less likely to participate in treatment or education programming. These youth are often mixed in with less serious offenders. Not only are the less serious youth intimidated at times, but are exposed to attitudes and demeanor that is not a positive influence. There is a need to separate out these youth to help protect the more vulnerable

youth. Often DJS has moved these "problem" youth from facility to facility. This does not effectively address the problem, but just moves it around where these youth impact each program in which they are placed.

The number of youth and the length of time that they await placement while in detention at Noyes has been of significant concern. The Confinement Review Unit has been very active in expediting youth moving on from the detention setting.

Pending placement and number of days in detention over 30 days

Number of pending placement youth	Youth in pending placement over 30 days
April 24th -27 youth in pending placement	6 youth over 30 days - 81days, 70 days, 66 days, 50 days, 48 days, and 36
June 15th – 19 youth in pending placement	7 youth over 30 days – 124, 104,63, 51, and 49
July 18th – 10 youth in pending placement	3 youth over 30 days – 133, 80, and 51
August 15th – 6 youth in pending placement	3 youth over 30 days – 107, 52, and 51
September 18th- 6 youth in pending placement	0 youth over 30 days

HEALTH AND MEDICAL:
Noyes has four contractual nurses while other facilities have nurses with PIN positions which include benefits. The head nurse at Noyes has left for a position that offers benefits.

- Though the nursing staff assert that it is not so, youth do complain that sometimes they are not seen by the nurse or doctor within a reasonable time when they place a sick call. This writer will continue to monitor the concerns.

Unabated for 30 Days or More:
The medical room is very limited in size at Noyes, and there are no clinic beds provided for youth that are sick or have conditions that are contagious. This concern was first noted in the January-March 2006 Quarterly Report.

FACILITY AND MAINTENANCE:
At one point during the summer when the local power grid was overwhelmed, Noyes lost power, and with it the air conditioners. This monitor was there during that day. The youth were locked down in extremely hot rooms. RICA did bring over ice pops, cold water, and ice cream to help cool off the residents. PEPCO was very slow to respond to the crisis. Noyes does not have a generator sufficient to maintain all functioning of the facility during a power outage.

Unabated for 30 Days or More:
The beds in the sleeping rooms provide tie off points that youth could, and have used in an attempted suicide. The concern regarding the beds at Noyes was noted in the October-December 2005 Quarterly Report.

Unabated for 30 Days or More:
The gym walls underneath the basketball goals used to have padding but only one pad is still on the wall. The padding is needed to help prevent injury to youth playing basketball. Reportedly, requests have been submitted for the padding. Additionally, now only one of the rims is in place. A work order has been submitted. This concern was raised in the October-December 2005 Quarterly Report. Without having a full time maintenance person on grounds it is much more difficult to have maintenance concerns addressed in a timely manner.

DJS Response:
As previously noted, all of the maintenance issues have been submitted and as soon as funding is made available, the repairs will take place. At this time, we do not have a date for completion.

ADVOCACY, INVESTIGATION, AND MONITORING:
DJS asserts that grievance forms are always available and replaced on the units as soon as staff become aware that they are needed.

The DJS Office of Responsibility and Accountability (OPRA) has been active at Noyes in investigating allegations of misconduct.

It was announced at a DJS Superintendent's meeting on June 29, 2006 that the Department was initiating a new policy with regard to the Office of the Attorney General Juvenile Justice Monitoring Unit. The new policy requires that the supervisor on duty at any DJS facility escort the monitor on his or her visit through the facility. Further it was stated that the monitor was not to interview a staff member without the supervisor present, and that youth were to be interviewed with the supervisor nearby. This policy compromises the ability of the monitor to gather crucial information that may lead to the discovery of concerns that affect the safety and security of youth. It is the expression of staff interviewed, including supervisory staff members that the perception of this policy is to inhibit staff and youth from divulging any information that might reflect negatively on DJS. Not only does this policy present the perception of impropriety but, is in addition, a violation of the Department's own standard.

DJS Detention Standard 7.3.2 Access to information: The Department shall ensure that internal and independent monitors and auditors are afforded the broadest possible

access, relevant to their particular function and consistent with notions of privacy, to all appropriate information, records, data, and to staff and youth of the facility that is being monitored.

DJS Response:
We are willing to revisit this procedure with suggestions from the monitors on how we can improve communication and verification of the monitor's findings. As this was a method for DJS staff to learn from the monitor.

THE WESTERN MARYLAND CHILDREN'S CENTER is a State owned and operated detention facility located in Washington County just outside of Hagerstown. WMCC is designed to accommodate a total of 24 youth in two 6 bed pods and one 12 bed pod. At present only males are housed at the facility.

STAFFING:
Staff members at WMCC continue to strive to maintain the positive and proactive culture for which they have become known. Youth frequently comment when asked that it is the best center where they have been placed. Staff members are described as fair, helpful and respectful to the residents.

Unabated for 30 Days or More:
WMCC has continued to face major staffing concerns during this reporting period. Staffing concerns at WMCC have been reported since the 2004 October-December Quarterly Report. Staff members have worked many hours of overtime which greatly increases the problem of fatigue and burnout. Interviewing and hiring of new staff members has been a priority, and slowly the efforts are making a difference. Youth center staff members had been temporarily assigned to WMCC to fill in Mondays through Thursdays. Most of those staff members have now returned to the Youth Centers. The deployment of Youth Center staff to WMCC was of great help, but further compromised staffing in the Youth Centers. Now that the experienced Youth Center staff members are gone, the challenge is to maintain safety and security given that the new staff members are untrained and inexperienced. This puts added pressure on the veteran WMCC staff members. At WMCC other staff members such as cooks, maintenance staff, and teachers help out when they can in providing supervision or in the control room. Community Case Managers have also volunteered to help out with coverage.

Though the population has been low during the later part of this quarter, at times when the center has been overpopulated staffing has been at a minimum which causes safety and security concerns.

DJS Response:
We will continue our recruitment, training and hiring efforts until such time as all positions are filled.

Unabated for 30 Days or More:
On the locked 6 bed pods there has been only a single staff member. At times the six bed pods have had to accommodate additional youth. When there is an "all staff duress call" in which all staff are required to respond to an incident, it creates a security risk as the

additional youth have no sleeping rooms in which to be secured, and must be left in the day room alone only being monitored by the video camera in the control room.

DJS Response:
Our goal is to always have sufficient numbers of experienced staff members on each shift. We will continue make every effort to meet the required standard of care for the facility.

Unabated for 30 Days or More:
On the second shift from 3pm to 11pm, in addition to the Supervisor, two roving staff members are needed especially when the facility is overcrowded. Staff on second shift and on weekends must attend to many additional tasks in addition to providing basic supervision. Administrative and educational staff members are not on site to help out as during the week. Family visitation, youth intakes, medical calls, special treatment needs, doing the laundry, and filling out reports as required following an incident are examples of situations that require additional staff. The intake of a new youth requires that two staff be present, and this rarely happens. When only one or even two people are available to accommodate all of these needs safety can be compromised. If several situations or incidents occurred simultaneously, it could become overwhelming.

Other positions also need to be filled.

DJS Response:
Our goal is to continue to meet the detention standards set for this facility**.**

Unabated for 30 Days or More:
Generally one Case Manager for 24 youth is sufficient. Having a second Case Manager at WMCC, however, has been extremely helpful. This position is especially needed when the facility has been overpopulated. This has happened frequently in the past.

Unabated for 30 Days or More:
The second Addictions Counselor position has also not been filled and a PIN is not available. The position will reportedly be filled when a PIN is provided. There is no time table provided.

Unabated for 30 Days or More:
Also, the second Social Worker position has not been filled. No PIN is available and no time table is given for filling the position, only noting that the job will be filled when a PIN is provided.

DJS Response:
Additional PINs have been requested. We can only begin the recruitment process when we have access to positions.

SAFETY AND SECURITY:
Safety and security is affected by staff shortage, staff fatigue, inexperienced new staff.

Unabated for 30 Days or More:
The control room staff person assumes a critical function, and in a crisis the functioning of that staff member could become pivotal in providing security. During this monitor's

visits the control room door is observed to be left open due to poor ventilation of the room. The control room should be equipped with an air conditioner. This concern and recommendation was first noted in the April-June 2006 Quarterly Report.

It has also been observed that the control room operator accidentally unlocked the hallway door while youth were passing by the door. This potentially allowed youth access to the control room.

DJS Response:
DJS provides training and a checklist for documentation of control room training for staff is being conducted. We continue to respond to this issue although it was rectified immediately several months ago.

Unabated for 30 Days or More:
The need for additional fencing to secure the outdoor recreation area has been cited numerous times. On June 28 a youth escaped from the outdoor recreation area by climbing over a fence. Though a lock has been placed on the gate to the area that the youth entered and scaled the fence, staff have identified several other fencing deficiencies that need to be corrected. Estimated installment of the needed fencing is about $87,000. The Department has not committed to providing the fencing. The need for additional security fencing for the outdoor recreation area has been noted since September 2004.

- On July 15, a Physical Plant problem incident report was made due to doors being unsecured as a result of a blown fuse. This presented a safety and security concern. At times problems with the locking of doors has been observed by this monitor. Doors that register as locked at times are not secured. The inner doors to the pods at times are left ajar.

- Frequently DJS has moved youth that are causing disturbance at another facility to WMCC. Sometimes, this is done without the transfer alert form being completed, especially when a youth goes to court and is transferred immediately. The receiving center then has none of the crucial background information about the incoming youth at the time of arrival. Also, medications do not accompany the youth. This presents a safety and security risk to youth and to staff.

Incidents at WMCC have continued as the table below indicates.

Month/Yr	Y on Y	Y on S	D/C act	U of F	GP. Dist.	Total
1-05	1			5		6
2-05				6		6
3-05	5	1		6		12
4-05	2			13		15
5-05	1			13		14
6-05				14		14
7-05	7		1	15		23
8-05	5	1		8		14
9-05	9			14		23
10-05	11	1		13		25
11-05	3			3		6

12-05	4			7		11
Total	48	3	1	117		**169**
Month/Yr	Y on Y	Y on S	D/C act	U of F	GP. Dist.	Total
1-06	6			6		12
2-06	7		1	6		14
3-06	3	1		7		11
4-06	4	0	1	12		17
5-06	4	2	0	7	Child Abuse by staff - 1	14
6-06	5	1	0	3	Escape - 1	10
Month/Yr	Y on Y	Y on S	D/C act	U of F	GP dist	
7-06	4	0	0	9		13
8-06	4	0	0	6	Attempt escape - 1	11
9-06 information not available to the monitor.						

Key: Y on Y (youth on youth assault) Y on S (youth on staff assault) D/C act (delinquent or criminal act) U of F (use of force) GP. Dist. (group disturbance)

- WMCC has not instituted a process whereby incidents are reviewed and used as training instruments to help staff evaluate their performance and correct mistakes. Understaffing makes this important type of training more difficult to undertake. The intention is to utilize such training as soon as staffing levels permit.

DJS Response:
The Department continues to work on this initiative.

Unabated for 30 Days or More:
As reported consistently even before installation, the presence of vitreous china toilets and sinks in the youths' sleeping rooms and bathrooms present a danger to youth and staff. A number of incidents involving broken china fixtures have occurred at WMCC and also at the Lower Eastern Shore Children's Center where the same material has been used. The Department agreed in January of 2004 to a remediation plan that included: replacing the vitreous fixtures with stainless steel in no less than two bedrooms immediately; replacing the vitreous fixtures with stainless steel upon any breakage or damage; and retrofitting the remaining vitreous china fixtures with stainless steel within a three year period. This agreement has not been acted upon by the Department.

DJS Response:
This is an issue that continues to be on the list of priorities, unfortunately, we do not have a date for resolution.

EDUCATION:
Overall, education has continued to be maintained as required at WMCC. When the population is over 31 youth, some of the classes are held on the pods in order to accommodate everyone. Teachers have commented that typically it is much more difficult to gain and maintain youth attention when teaching on the pods.

Most teachers coordinate effectively with the direct care staff. At times students and staff have reported that a particular teacher picks unnecessarily on youth often causing problems that flair up either during or after the school period. Teamwork and communication should be improved so that treatment, including confrontation, is coordinated to best serve the youth.

PROGRAMMING:
The experienced staff members at WMCC have continued to strive to maintain the effective culture that values an attitude of respect for youth, and an expectation of positive behavior on the part of youth. Positive behaviors are rewarded and negative behaviors are confronted. Routine and order is generally maintained and this helps provide a sense of predictability and security. Even "special assignment" youth that have caused significant problems at other facilities have generally responded well to the culture at WMCC. When the facility has been understaffed and over populated, however, especially with having special assignment youth enrolled, it has stressed the culture excessively and has made it very challenging to maintain the same norms that otherwise typify the programming at WMCC.

- Sometimes it has been difficult for staff members to maintain consistency in the application of policy and procedure, and there has not been time for staff meetings where this and other issues could be addressed.

DJS Response:
Meetings are held when necessary to ensure that staff are applying policies and procedures appropriately.

The program at WMCC is guided by the BMS (Behavior Management System). The creative multi-level system offers youth graduated rewards and consequences. Each level is designated by a color band which the youth wear on their wrists to identify the level they are currently on. Each day the youths' behavior, progress, set backs, accomplishments, challenges, frustrations and goals are evaluated. Each day every youth has the chance to advance to a higher level, or lose a level or levels as indicated by evidence of the above.

Some youths remain in detention at WMCC for extended lengths of time and feel that they are doing "dead" time. On August 2, 2006, WMCC had a population of 23. Of the 23 youth, 5 youth had lengths of stay over 30 days; 31, 34, 40, 50, and 100 days. Of the 5 youth 3 were pending a court hearing, and 2 were pending a placement.

The Confinement Review Unit, along with Residential Case Managers, and DJS Area III Community Services personnel have worked to expedite youths' movement through detention. A joint meeting is held every Tuesday to review each youth and develop a plan to facilitate the youths' to post detention placement, as determined by the adjudication and disposition process.

DJS Response:
All youth are receiving intensified efforts to expedite the appropriate placement beyond detention through the assistance of the Confinement Review Unit.

- Activities provided for the youth on weekends or during weekdays when there is no school are generally limited to watching TV, movies, and recreation in the gymnasium. Staff members do try to provide some programming in the form of Competency Training sessions, which is centered on a treatment or health topic. Holidays are also celebrated. However, ongoing activities such as art, music, story telling, drama, or crafts that could be provided by volunteer groups or individuals have not been developed.

HEALTH AND MEDICAL:
Health and medical services at WMCC are provided as needed. This monitor has not been made aware of major difficulties in this aspect of delivery of service to the youth. There seems to be very good cooperation and communication between the direct care staff and medical personnel.

FACILITY AND MAINTENANCE:
The security fencing concern noted above under Safety and Security has been reported numerously without correction. Outdoor recreation is thus limited to those times when sufficient staffing is available to ensure security.

As noted above, the vitreous china fixtures continue to pose a threat to youth and to staff. This concern is now in its third year of being reported. To date no one has been seriously hurt by the shards of broken china. Only superficial cuts have made to a youth's arm thus far. The fixtures have not been made safe by the removal of the toilet seats.

Suicide resistant beds and window tinting has finally been completed at WMCC.

The control room door is often kept open because of poor ventilation of the room. This presents a potential breach of security. There is no air conditioner provided.

Unabated for 30 Days or More:
The carpets are in poor condition in the facility. Reportedly, new rubberized flooring is being considered.

There are no snow guards on the roof to prevent damage to the gutters.

ADVOCACY, INVESTIGATION, AND MONITORING:
Unabated for 30 Days or More:
On June 29, 2006, it was announced at a DJS Superintendent's meeting that the Department was initiating a new policy with regard to the Office of the Attorney General Juvenile Justice Monitoring Unit. The new policy requires that the supervisor on duty at any DJS facility escort the monitor on his or her visit through the facility. Further it was stated that the monitor was not to interview a staff member without the supervisor present, and that youth were to be interviewed with the supervisor nearby. This policy compromises the ability of the monitor to gather crucial information that may lead to the discovery of concerns that affect the safety and security of youth. It is the expression of staff interviewed, including supervisory staff members that the perception of this policy

is to inhibit staff and youth from divulging any information that might reflect poorly on DJS. Not only does this policy present the perception of impropriety but, is in addition, a violation of the Department's own standard.

DJS Detention Standard 7.3.2 Access to information: The Department shall ensure that internal and independent monitors and auditors are afforded the broadest possible access, relevant to their particular function and consistent with notions of privacy, to all appropriate information, records, data, and to staff and youth of the facility that is being monitored.

DJS Response:
We are willing to revisit this procedure with suggestions from the monitors on how we can improve communication and verification of the monitor's findings. As this was a method for DJS staff to learn from the monitor.

Many of the Community Case Managers maintain regular contact and visitation with youth at WMCC. Some Case Managers maintain little or no contact. Special assignment youth that have been placed at WMCC especially from Baltimore City have received very little contact from their Community Case Managers. Family members have difficulty visiting WMCC from Baltimore or places even more distant.

DJS Response:
There appears to be some confusion about the law. Courts and Judicial Proceedings § 3-8A-25 indicates the following:

If a child is committed under this subtitle to an individual or to a public or private agency or institution:

(1) The juvenile counselor shall visit the child at the child's placement no less than once every month, if the placement is in state.
(2) The court may order the juvenile counselor to visit the child more frequently than required by item (1) or this section if the court deems it to be in the child's best interest; and
(3) The court may require the custodian to file periodic written progress reports, with recommendations for further supervision, treatment or rehabilitation.

The youth at WMCC are detained, not committed for placement; therefore the rule quoted does not apply.

WILLIAM DONALD SCHAEFER HOUSE is owned and operated by the Department of Juvenile Services, accommodates 19 male youth, and provides a three-month substance abuse recovery program. The facility is located in a nice setting on Druid Park Lake Drive in Baltimore.

The program will be temporarily moved to the Maryland Youth Residence Center in October during much needed repair and renovation of the Schaefer House facility. MYRC is located at 721 Woodbourne Avenue in Baltimore. The phone number there for contact with the Schaefer House program will be 410-433-6041. MYRC typically houses

around 20 shelter care youth and has a capacity of 30 beds. It is unclear as to how both youth programs will share the facility.

STAFFING:
Due to training requirements, vacations, and sick time at times there is not enough staff to maintain a 1 to 6 staff/youth ratio.

DJS Response:
This facility does not require a 6-1 staff to student ratio; it is not a detention facility.

Most of the staff members are very diligent and committed in their work. Some staff members have displayed un-professionalism in their language with youth. Staff meetings are used to enhance teamwork and professionalism.

Schaefer House used to have a full-time maintenance/grounds person. This position is greatly needed at the facility. Reportedly a request for a full time maintenance person will be submitted during the next budget cycle.

DJS Response:
As stated, a request has been made for a full time maintenance person.

SAFETY/SECURITY:
The windows in the dorm rooms do not open. This potentially presents a very serious safety concern if there was an emergency where the only exit for the residents was through the dorm windows.

DJS Response:
All maintenance issues should be resolved once the contractors complete the maintenance on the building.

EDUCATION:
The education program is cited by youth as being of value. Educators are very helpful. The GED program has also been very successful with a high percentage of youth passing the exam.

PROGRAMMING:
The program consists of individual and group counseling, education, and additional on and off grounds activities. The drug treatment groups that have been observed appear to be productive and the youth participate actively in the discussions. Youth interviewed have commented that they have received a lot of valuable information about the negative impact of using drugs. Alcoholics Anonymous and Narcotic Anonymous meetings are attended weekly. Most youth indicate that they do want to become drug free.

Schaefer House has implemented an “upper level” room for youth that demonstrate significant progress in their treatment. Youth assigned to this dorm room have a later bedtime, are able to enjoy television, and they have a radio in their room. A second upper level dorm room is reportedly being created. This program enhancement is creative and should help youth motivate themselves to earn the privilege.

Family visitation is accommodated on Sunday afternoons from 1:00 PM to 4:00 PM.

- When asked about activities, youth often have complained that they sit too much because of lack of variety of activities.

- They also say that they do not receive an hour of large muscle exercise each day, and staff members confirm that a youth that is being sanctioned might not get recreation. The Schaefer House does have an arrangement with the YMCA, and at times youth are taken to the Y for activities and exercise. There is new exercise equipment in the basement recreation area, and finally it has been assembled. The recreation room in the basement is temporarily off limits however because of the need to conduct lead abatement, and renovation. This impacts the ability of providing exercise opportunities. Youth also comment that they are not allowed to do sit-ups or pushups on their own time.

DJS Response:
Youth are involved in large muscle exercise daily. In inclement weather the youth are taken to the YMCA.

Following completion of the program Schaefer House tracks youth at 30, 60, and 90 days. Approximately 70% to 75% of the youth maintain compliance with their treatment goals 30 days after being released. At 60 days after release, approximately 60% to 65% of the youth maintained compliance, and at 90 days approximately 45% to 55% maintained compliance.

- Although in general the program appears to be successful in helping youth achieve treatment goals, more intensive aftercare services are needed to help youth maintain the successes post release.

HEALTH/MEDICAL:
DJS provides a nurse who is available on a daily basis for sick call requests. To see the nurse, youth fill out a "Sick Call Request Sheet" and put it in the Sick Call Box. If a youth does not have a medical card or personal insurance the program reportedly does not have a fund to pay for medical treatment.

DJS Response:
All youth receive required medical care, with or without medical insurance. The nurse is available to treat all youth.

FACILITY MAINTENANCE:
The Schaefer House facility continues to be in poor condition overall as of this writing. Also the youth complain of bed bugs, worms in the showers and mice in the facility. The exterminators come on a monthly basis and more often when called.

There is a plan for some repair and renovation of the facility. Current construction is taking place in refurbishing the bathroom on the second floor. Exterior painting and window repair is badly needed. The needed painting is slated to take place in October 2006, with window replacement reported to be planed for later this fall. Interior carpet will reportedly be replaced and the basement/recreation room will be renovated. The third floor bathroom will also be renovated.

- Window air conditioners are used. According to the architect this has contributed to the damage to the windows and to the exterior painted surfaces. Also, the windows cannot be opened, and the screens cannot be cleaned and have accumulated dirt and debris. Not being able to open the screens could be dangerous to youth if there was an emergency.

- Carpeting: The carpeting is in poor condition throughout the facility.

- Phone System: The phone system upgrade has not been completed. Getting through has been problematic at times. New phone lines have been installed but have not been hooked up.

- Basketball court: There is no padding on the goal posts.

- Kitchen: Though it was reported that the Department has contracted with a cleaning company to complete a power cleaning in October 2005, as of this writing the project has not been undertaken.

    - The stoves are greasy and dirty.
    - 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.
    - The kitchen floor tile is old and discolored.
    - The ice machine has not worked for over a year.

- Cafeteria: The flooring in the cafeteria needs to be replaced. A requisition has been submitted to the Department but no time line for replacement has been given.

- Sunroom: Caulking is missing around the windows. This allows outside air to come into the room. The ceiling vent covers are missing.

- Dayroom: The flooring in the back dayroom is soft.

- Bedrooms: Twenty new dressers and chests have been provided. The old beds and chests are covered with graffiti, some of which is gang related. It was reported that they would be sanded but this has not happened.

- 2nd floor bathroom and 3rd floor bathroom: A plan for reconstruction has been approved, and construction has begun.

- Laundry Room: A new heavy-duty washer and heavy-duty dryer have been installed in the hallway behind the kitchen.

- Boiler Room: It is reported that the heating system is not sufficient. A new expansion tank has been installed, and a new outside thermostat was also installed.

- Recreation Room: In the recreation area the walls are flaking and need to be sealed and painted. Renovation is planned to commence in October of 2006.

DJS Response:
The contractors will complete many of the maintenance issues will be finalized.

ADVOCACY/INVESTIGATIONS/MONITORING:
Upon visitation September 20, 2006 the youth interviewed could not identify the Child Advocate. The grievance box had no grievance forms available. A staff member did provide the forms and identified the Child Advocate as Ms. Booth.

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 12-bed group home that serves male youth (ages 15½ - 18) who have emotional and behavioral problems. Youth generally stay in the program from 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.

Mount Clare House was not monitored during the third quarter due to shortage of staff in the Juvenile Justice Monitoring Unit. This facility will be monitored during the fourth quarter.