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STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL

QUARTERLY REPORT
4TH QUARTER, 2006
FINAL FINDINGS AND RECOMMENDATIONS

May 1, 2007

The Honorable Donald DeVore
Department of Juvenile Services
One Center Plaza
120 W. Fayette Street
Baltimore, MD 21201

Dear Secretary DeVore:

Enclosed please find the most recent Quarterly Report from the Office of the Attorney General's Juvenile Justice Monitoring Unit.

This Quarterly Report covers the period from October 1, 2006 through December 31, 2006. It discusses current conditions in Department of Juvenile Services facilities as well as those conditions requiring corrective action that have remained unabated since the issuance of the last Quarterly Report.

Over the next 90 days, our agencies' Memorandum of Agreement (MOA) requires that we meet with the goal of negotiating an agreed-upon plan to correct all deficiencies noted in the reports. The Department of Juvenile Services should submit any preliminary Corrective Action Plans to us by May 29, 2007, and our final Comprehensive Monitoring Report with Corrective Action Plans must be completed by July 11, 2007.

I believe this should give us ample time to develop agreed-upon and appropriate corrective actions and to begin implementing these plans. Although these deadlines are set by our MOA, I would be pleased to discuss a different

process for development of Corrective Action Plans that would move us from response and negotiation to “action” more quickly.

I hope that this report assists you as you develop strategies to enhance programs and services provided to the youth of Maryland. I look forward to continuing to work with you and your staff toward that goal.

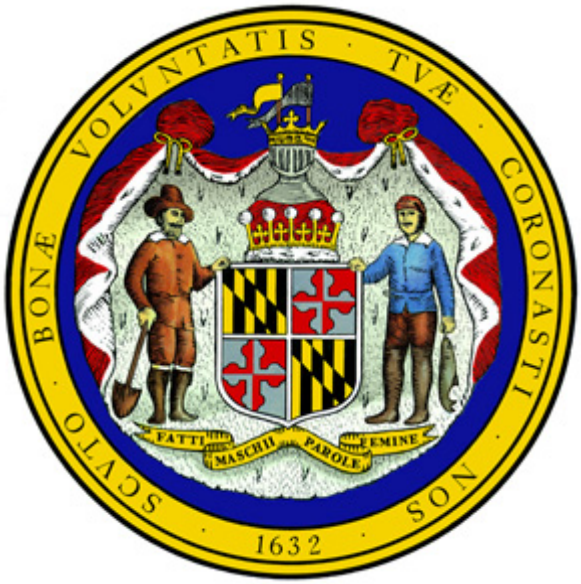
Respectfully submitted,

Marlana Valdez
Director
Juvenile Justice Monitoring Unit

Enclosure

Cc: The Honorable Thomas V. Miller, Jr., President of the Senate
The Honorable Michael E. Busch, Speaker of the House of Delegates
Arlene F. Lee, Executive Director, Governor’s Office for Children
Katherine Winfree, Chief Deputy Attorney General, Office of the Attorney General

Electronic Copies: John Dixon, Deputy Secretary, DJS
Frances Mendez, Deputy Secretary, DJS
Roberto “Tito” Rodriguez, Assistant Secretary, DJS
James Smith, Assistant Secretary, DJS
Phillip O’Donnell, Director, OPRA, DJS
Robert Fontaine, Principal Counsel, DJS
Marian Daniel, Program Manager, DJS



OFFICE OF THE ATTORNEY GENERAL

THE JUVENILE JUSTICE MONITORING UNIT

FINAL QUARTERLY REPORT

OCTOBER 1, 2006 – DECEMBER 31, 2006

QUARTERLY REPORT
OCTOBER – DECEMBER, 2006

INTRODUCTION

The Juvenile Justice Monitoring Unit (JJMU) Quarterly Report for October-December, 2006 summarizes major concerns in Department of Juvenile Services (DJS) residential facilities identified during this reporting period as well as deficiencies or concerns reported in earlier periods that have not been corrected.

Between August and November 2006, the Juvenile Justice Monitoring Unit (JJMU) experienced significant loss of staff. The Director, Deputy Director, and one Monitor left the Unit to assume other positions. The two Monitors remaining on staff, Philip J. (Jeff) Merson and Timothy Snyder worked diligently to maintain visitation and reporting schedules for nineteen facilities. They also completed the July-September, 2006 Quarterly Report and the FY 2006 Annual Report.

As of the date of this report, an additional Monitor and a Director have joined the staff of the Unit.

In the interest of providing more comprehensive information to our readers, with this report the Juvenile Justice Monitoring Unit introduces a new format for its Quarterly Reports. This report differs from our past quarterly reporting practice in the following ways:

1. The report is organized primarily by issue – systemic issues or conditions present in more than one facility. The report highlights issues most critical to the health, safety, and humane treatment of youth in Department of Juvenile Services' care.

   Each Quarterly Report may focus on a different set of issues. Issues discussed in this report include:

   - Detention and Pending Placement
   - Staffing
   - Safety and Security

Our Quarterly Report for the 1st Quarter, 2007 will discuss the following issues:

- Population
- Education
- Programming

- Health/Medical
- Advocacy, Investigations, and Reporting

2. Within the discussion of each issue, we provide information on individual facilities. Readers are also referred to the Comprehensive Timely Report for the 4th Quarter, 2006 which includes detailed findings and recommendations for each facility.

   Our Comprehensive Timely Report for the 4th Quarter, 2006 may be found on our website at www.oag.state.md.us/jjmu. All reports of the Juvenile Justice Monitor from 2002 – 2006 may be found there.

3. In addition to identifying critical and chronic systemic issues, our future Quarterly Reports will discuss factors that may contribute to these conditions – both inside and outside the Department of Juvenile Services.

   We believe that some problems in DJS facilities cannot be solved by the Department alone – some improvements will require better interagency collaboration, changes in other agencies' practices, new state regulations or court rules, or act of the General Assembly. While the Monitor's reports do not offer a scientific assessment of the root causes of problems, they can at least provide a starting point for discussion.

4. At the end of the report, as required by law, we provide a complete listing of all conditions noted in earlier reports that have not been corrected and the period of time during which the condition has remained unabated.

5. Finally, where appropriate, we also feature facilities or programs that have implemented programs worthy of replication.

DETENTION AND PENDING PLACEMENT PERIODS OF CONFINEMENT

Overview

Maryland has seven secure detention facilities in which youth are held before adjudication by the Court or after adjudication while they are awaiting placement in a treatment program or residential facility (pending placement status). These facilities are:

Baltimore City Juvenile Justice Center (BCJJC)
J. DeWeese Carter Children's Center (Carter)
Cheltenham Youth Facility (Cheltenham)
Charles H. Hickey, Jr. School (Hickey)
Lower Eastern Shore Children's Center (LESCC)
Alfred D. Noyes Children's Center (Noyes)
Thomas J.S. Waxter Children's Center (Waxter)
Western Maryland Children's Center (WMCC)

In some of these facilities, youth are often held far beyond the time limits set by law for detention. Many youth are also held for extended periods of time after being adjudicated delinquent but before being placed in an appropriate treatment or rehabilitative program – a sort of legal "limbo" (the youth call it "dead time") during which no Maryland statutes or Department of Juvenile Services standards appear to govern their conditions of confinement or the treatment they must be afforded.

A variety of factors may contribute to extremely long detention periods before adjudication/disposition hearings, including crowded court dockets or waivers by the child's attorney. Lengthy pending placement periods may be attributable to inefficient placement practices, placement shortages, and lack of community-based non-residential alternatives to residential care.

In 2006, DJS reportedly conducted a Confinement Review Study to analyze problems with detention and pending placement. A draft of that study was to be available for review in early November, but the Monitor has not received a copy, and it is unclear whether the report was ever completed.

Applicable Standards

Maryland statutes and regulations set conditions under which children may be held in secure detention or confinement. These provisions require:

1. "(A) child may be placed in detention…if such action is required to protect the child or others or the child is likely to leave the jurisdiction of the court." **Md. Courts & Jud. Proc. Ann. § 3-8A-15(b) & (d).**

2. "An adjudicatory…hearing shall be held no later than 30 days after the date a petition for detention…is granted…" **Md. Courts & Jud. Proc. Ann. § 3-8A-15(d)(6).**

3. "If a child is detained…after an adjudicatory hearing, a disposition hearing shall be held no later than 14 days after the adjudicatory hearing." **Md. Courts & Jud. Proc. Ann. § 3-8A-15(d)(6)(ii).**

4. "If a child remains in…detention…for more than 25 days after the court has made a disposition…the Department of Juvenile Services shall…on the first available court date after the 25th day…appear at a hearing with the child to explain the reasons for continued detention; and every 25th day thereafter, appear at another hearing before the court with the child to explain the reasons for continued detention. **Md. Courts & Jud. Proc. Ann. § 3-8A-15(k).**

Key Findings

Several detention facilities continue to experience significant problems with the length of time youth are held in detention and pending placement. In 2006, several youth were held in excess of 150 days (5 months) while awaiting an adjudicatory hearing, and at least two youth were held in excess of 200 days (6 months). Several youth also waited in excess of 200 days (6 months) to receive a placement following adjudication and pending placement periods of over 90 days (3 months) were not uncommon. All means of reducing these detention periods to acceptable periods *within the limits established by law* must be explored.

While Maryland statutes and standards place strict time limits on detention periods, the issue for children awaiting placement is more complex. DJS argues that neither its own detention standards nor Maryland statutory and regulatory time limits on detention apply to children in pending placement status even though these children are housed in the same facilities, and sometimes in the same units, as children being detained before adjudication.

DJS has never promulgated separate standards for youth in pending placement status. Theoretically, with no standards on pending placement, youth could be held indefinitely without placement in an appropriate treatment or rehabilitative program. In fact, many youth do languish for months waiting to be assigned to an appropriate placement.

We believe a number of potential factors may contribute to overly long pending placement periods. A common justification for long pending placement periods is that some youth are harder to place than others. This response begs the questions - Does Maryland need additional residential facilities for certain populations? Could earlier assessment of special needs/mental health issues speed placement of these youth?

In view of the seriousness of this issue, we believe that all potential contributing factors, including circumstances external to the Department, should be explored. Such an inquiry might include the following questions, among others:

1. Juvenile Courts
    - Are youth regularly brought before judges for hearings on their continued detention as required by law?
    - If so, are these hearings substantive or merely pro forma?
    - Do overcrowded court dockets contribute to delays?

2. Defense Attorneys
    - Do some children's attorneys waive hearings on extension of detention or pending placement periods?
    - If so, do their clients (the youth) consent to waivers?
    - Do some children's attorneys waive hearings without good cause?

3. DJS
    - Why do some facilities have shorter (or longer) average detention and pending placement stays than others?
    - Why do some DJS case management offices place youth more quickly (or more slowly) than others?
    - How might successful DJS case management practices be replicated throughout the state?
    - Should additional facilities for special needs youth be opened?
    - Could early assessment shorten pending placement stays?

4. Secure Placements for Males

    All males committed to secure facilities must be placed out of state.[1] Many procedural rules govern the out-of-state placement process, including a requirement that youth be rejected in writing by all available in-state facilities, and that the out-of-state placement be approved by the State Coordinating Council.[2]

    - How much do these processes slow the placement of youth in out-of-state facilities?

[1] Since the closure of the Hickey commitment program in 1999, Maryland has had no in-state secure commitment facilities for males. All males committed to secure placement are placed out-of-state.

[2] State/Local Coordinating Council, Governor's Office for Children.

- Are there ways to expedite these processes and eliminate red tape?
- What steps are being taken to develop in-state secure care resources?

Additional relevant considerations and recommendations may be found in reports of The Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative (JDAI). This project has studied detention and pending placement processes across the U.S. and identified a number of methods for reducing detention periods. Readers are referred to the Foundation's monograph series Pathways to Juvenile Detention Reform, and for recommendations regarding pending placement youth, to Special Detention Cases - Minors in Post-Adjudication and Post-Disposition Detention.[3] The Foundation's Juvenile Detention Alternatives Initiative is currently being piloted in seven states – one of the pilot sites is the Baltimore City Juvenile Justice Center (BCJJC).

Detention and pending placement statistics for individual facilities for this quarter follow. These statistics provide a "snapshot" of conditions in a particular facility and are drawn from random sample dates. In subsequent reports, we will provide full detention and pending placement data for each facility by quarter.

BCJJC

Detention

In detention for more than 60 days – 24 youth
In detention for more than 100 days – 11 youth
In detention for more than 150 days – 3 youth
In detention for 195 days – 1 youth

Pending Placement:

In pending placement for more than 130 days – 3 youth
In pending placement for more than 260 days – 1 youth[4]

Carter

No figures were available for this reporting period but will be included in the 1st Quarter, 2007 report.

[3] Steinhart, David, Pathways to Juvenile Detention Reform – Special Detention Cases, Volume 9, 1999. (Available from the Annie E. Casey Foundation, 410-547-6600, www.aecf.org.)

[4] November 7, 2006

Cheltentham

Detention

In detention for more than 100 days – 5 youth
In detention for more than 150 days – 1 youth
In detention for 239 days – 1 youth

Pending Placement

In pending placement for more than 100 days – 6 youth
In pending placement for more than 227 days – 1 youth[5]

Hickey

No statistics were available for this reporting period but will be included in the 1st Quarter, 2007 report.

LESCC

In pending placement for more than 100 days – 3 youth
In pending placement for more than 150 days – 1 youth[6]

Noyes

Earlier in 2006, length of detention and pending placement periods was a significant issue at Noyes, with youth awaiting placement for periods as long as 133 days. This facility's numbers significantly improved during this reporting period. At several points during this quarter, Noyes had no youth in pending placement for more than 30 days. At the end of the quarter, its statistics were:

In pending placement for more than 30 days – 3
In pending placement for more than 50 days – 3 (longest was 62 days)[7]

The Noyes Confinement Review Unit has been very active in expediting the movement of youth from detention and pending placement. (See discussion of confinement review below.)

[5] December 18, 2006
[6] November 11, 2006
[7] December 18, 2006

Waxter

In detention for more than 30 days – 5 (longest was 49 days)

In pending placement for more than 30 days – 2 (longest was 45 days)[8]

WMCC

No statistics were available for this reporting period but will be included in the 1st Quarter, 2007 report.

Confinement Review

While data was not available for all facilities for this reporting period and will be included in our 1st Quarter, 2007 report, several facilities have robust Confinement Review programs that appear to contribute to reducing confinement periods. Noyes, WMCC and LESCC convene weekly Confinement Review meetings at which updates on each youth in the facility are provided and plans are developed to ensure prompt movement from detention and pending placement status.

While all facilities convene Confinement Review meetings, some have been more successful than others in reducing detention and pending placement confinement periods, and the reasons for the differences in outcomes should be studied.

Recommendations

1. The Department should conduct its own special review of the cases of all youth who have been in either detention or pending placement for more than 60 days to ensure that their cases are being processed in a timely manner.

2. DJS should immediately develop separate standards for "pending placement" youth.

3. The Department should complete the Confinement Review study begun in 2006 to uncover the reasons for lengthy or inappropriate detention and pending placement periods. All potential causes of delay, including ineffective confinement review or case management practices, scarce facilities/programs, attorney waivers, court practices, and/or out-of-state placement issues should be explored.

[8] November 27, 2006

4. Current practices that result in lengthy detention and/or pending placement confinements should be replaced with processes that move children out of detention and pending placement as quickly as possible.

5. Confinement review programs at facilities that have successfully reduced detention and pending placement periods should be replicated at other facilities.

6. The Department should expand the Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative (now being piloted at the Baltimore City Juvenile Justice Center [BCJJC]) to reduce the time youth spend in detention and pending placement.

STAFFING

Overview

Most DJS residential facilities suffer from a severe shortage of well-trained and experienced staff – a problem consistently reported by the Juvenile Justice Monitoring Unit for several years.

There is reason for some optimism on this front. In recent months, several facility superintendents have taken individual initiative to expedite hiring of staff, and they have experienced some success in decreasing their staff vacancies. DJS has changed several hiring practices to reduce the time it takes to interview, train, and place staff. In addition, as of the date of this report, DJS has secured a FY 2007-2008 supplemental appropriation of approximately $1.2 million to add 30 full-time staff positions.

Much work remains to be done, however, to ensure that facilities are fully staffed with well-trained and experienced employees. Staffing is critical to all other residential facility operations. "The absence of sufficient numbers of trained and skilled staff…makes it virtually impossible to provide youth with consistent care, maintain custody and supervision, and provide a safe environment."[9]

Applicable Standards

"Youth to staff ratios developed by the Department shall ensure adequate supervision of youth. The allocation, deployment and assignment of resources/personnel to each facility shall be based on:

1. the budgeted population operating capacity;
2. the level of risk and needs of the population;
3. facility programs and services; and
4. physical plant architecture."

Maryland Standards for Juvenile Detention Facilities, 5.1.3.

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

Key Findings

A number of factors contribute to staff shortages. Significantly, salary scales for DJS direct care workers continue to lag behind those for Department of

[9] Letter from Wan J. Kim, Assistant Attorney General, U.S. Department of Justice, on Investigation of the Baltimore City Juvenile Justice Center in Baltimore, Maryland, August 7, 2006, pp. 7-8.

Corrections workers, and DJS loses many applicants and staff to employment in the prison system.[10]

Contract Positions

This problem is exacerbated by the large number of contract positions (positions without benefits) in DJS facilities. At Noyes, for example, the one full-time nursing position is a contract position, and the nurse left for a job with benefits several months ago. Since that time, the superintendent has been unable to fill the position.

Several facilities rely entirely on contract nursing services – a medical personnel agency provides nurses and other medical staff. The heavy reliance on contract medical personnel results in many temporary staff rotating through facilities. Youth residential facilities desperately need the opposite – permanent medical staff who can develop relationships with individual youth, enabling them to better meet medical needs while providing some degree of permanence in these children's lives. We urge the Department to give this issue serious consideration and reduce the number of contract positions system-wide.

Centralized Hiring Processes

Historically, the centralized hiring process has added almost unimaginable delays to the hiring process – reportedly it frequently takes *in excess of a full year* to fill a single position. Once a facility has a position vacancy, it must ask Headquarters for permission to fill the vacancy – it can take six months or more to receive this preliminary approval. Once Headquarters approves filling the vacancy, it can take as long as an additional six months to complete the hiring process. The Department has made some gains in reducing lag time, and a psychological test that was unnecessarily screening out qualified applicants has been modified.

DJS uses Maryland Correctional Training Commission (MCTC) standards to screen applicants for employment. MCTC standards prohibit the employment of any applicant with a history of illegal drug use in the past five years, excluding many otherwise qualified prospective candidates from employment. We urge the elimination of employment practices that needlessly screen out qualified applicants from employment, and additionally, we urge the Department to explore all means of quickly bringing in additional direct care workers.

[10] Also Department of Corrections (DOC) workers become eligible for retirement after 20 years of service while DJS workers are not eligible until completing 30 years of service.

Overtime

While most facilities are able to meet their targeted staff:youth ratio, they do so through extensive use of overtime hours and pay. Excessive use of overtime has a direct impact not only on staff morale, but on security, safety, and quality of care. The U.S. Department of Justice Monitors noted in their Third Monitors' Report on Hickey and Cheltenham:

> "One of the most pervasive findings of this monitoring period, reported by staff, administrators, and youth alike, is that staff are overworked and exhausted. Most staff serve double shifts routinely throughout the week. Not only does this have an obvious effect on morale, but also results in a workforce whose decision making skills, patience, and reaction times are not at optimum levels. Challenges to compliance with most provisions noted in the protection from harm and suicide prevention sections of this Agreement are tied in some fashion to availability of staff."[11]

While the federal Monitors' comments were limited to Cheltenham and Hickey, we saw a pervasive pattern of staff burnout throughout the system.

The overtime issue is further complicated by low base salaries - direct care staff depend on overtime pay to supplement their base salaries, and if programs are fully staffed, eliminating the need for overtime, some staff members leave for higher paying jobs.

Training

When facilities suffer from staff shortages, training for existing staff is also affected. Many staff report that they are unable to attend required annual training because no one is available to cover their shifts. Again, lack of training can be directly linked to other problems, and we see a vicious cycle – staff shortages leading to lack of training, decline in safety, low morale, and ultimately high turnover.

Temporary Staff Transfers

We note one final systemic issue. When facilities are short staffed, DJS frequently moves employees from a fully-staffed facility on a temporary basis. For example, when Noyes was short-staffed in this quarter, WMCC staff were reassigned there, and Youth Center staff were reassigned to cover the resulting shortages at WMCC.

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[11] Settlement Agreement between the State of Maryland and the United State Department of Justice, Third Monitor's Report, December 22, 2006., pp. 6-7.

This practice compromised programming at both WMCC and the Youth Centers. In addition, security and safety at WMCC was compromised because Youth Center staff are not appropriately trained to work in a secure detention setting. While WMCC and Youth Center staff were able to return to their primary duty posts by the end of the quarter, in the future DJS should refrain from temporarily reassigning staff.

Details on individual facilities follow:

Allegany Girls Group Home (Allegany)

No issues in this reporting period. Allegany maintains a minimum of two staff on duty at all times, and mandatory staff training requirements are being met.

Baltimore City Juvenile Justice Center (BCJJC)

Conditions Requiring Corrective Action

- Inadequate staff/youth ratios (Unabated for 90 Days or More)
- Excessive use of overtime to meet staffing ratios (Unabated for 90 Days or More)
- Inadequate staffing of Master Control (Unabated for 90 days or More)

Staff members are working a significant amount of overtime in an attempt to maintain a 1:6 staffing ratio. It is somewhat difficult to determine exactly how many staff are on duty during a given shift because the shift commander says that "actual" staffing and "recorded" staffing differ.

Master Control should be staffed with two persons at all times. Master Control staff must manage the security system (cameras and doors), radio, phones and visitors/staff, logs and population movement. These duties place too much stress on one employee, particularly given the critical nature of Master Control.

The Monitor promotes having two staff persons on every unit, regardless of the number of youth assigned to the unit.

J. Deweese Carter Children's Center (Carter)

Conditions Requiring Corrective Action

- Inadequate number of staff positions
  - Nurse (evening shift)
  - Recreation Coordinator

By the end of this quarter, the facility administrator said all open positions had been filled. Carter continues to need an evening shift nurse and a full-time recreation coordinator, but the Department has not approved establishment of the positions.

Cheltenham Youth Facility (CYF)

Conditions Requiring Corrective Action

- Staff vacancies (Unabated for 90 Days or More)
- Excessive use of overtime to meet staffing ratios

Cheltenham still has vacancies in all areas and is making an effort to maintain proper staff/youth ratios by the use of overtime personnel. The part-time contractual staff had not started as of December 18, 2006.

Guide Structured Shelter Care (GUIDE)

No issues in this reporting period. According to GUIDE records, there are no staff vacancies, and during this reporting period JJMU Monitors observed eight youth in the facility with two direct care staff and one admissions staff.

Charles H. Hickey School (Hickey)

Conditions Requiring Corrective Action

- Staff vacancies (Unabated for 30 Days or More)
- Excessive use of overtime to meet staffing ratios

Positions remain unfilled at Hickey, and overtime is still being used to maintain minimum staffing ratios.

Lower Eastern Shore Children's Center (LESCC)

Conditions Requiring Corrective Action

- Inadequate numbers of male staff or male role models (Unabated for 90 Days or More)

Although some overtime is still being used to ensure appropriate staffing levels, during Monitor visits a staffing ratio of 1:6 was being maintained. Administration noted that the facility is fully staffed unless there are call-out or training issues.

LESCC continues to lack male staff members. During this quarter, the administration reported that 68% of the direct care staff members were female.

Several researchers have discussed the importance of providing positive male role modeling for adolescents, and at least one study has focused specifically on the need among young African American males.[12] While DJS might provide positive role models via mentoring and other volunteer programs, recruiting additional male staff members is critically important.

Maryland Youth Residence Center (MYRC)

Conditions Requiring Corrective Action

- Inadequate staff/youth ratios (Unabated for 290 Days or More)
- Inadequate numbers of male staff or male role models (Unabated for 90 Days or More)

There is normally one direct care staff working on each unit but this office continues to recommend two staff on each unit to provide security and safety. The 1:12 staff:youth ratio maintained by MYRC is not conducive to providing a safe environment.

During this quarter, the facility had eight staffing vacancies, two more vacancies than were reported last quarter.

According to administration, of the 25 direct care staff members only 7 are males. This is a 28% ratio of male adult staff working with a 100% population of male juvenile offenders, limiting opportunities for youth to observe and engage with positive male role models. (See p. 15 for additional discussion.)

Mount Clare House

No issues in this reporting period. Mount Clare House's has dedicated staff with many years of experience.

Alfred D. Noyes Children's Center (Noyes)

Conditions Requiring Corrective Action

- Inadequate permanent (PINS) positions (Unabated for 290 Days or More)
- Inadequate staff/youth ratio (Unabated for 290 Days or More)
- Staff vacancies
  - 2 full-time Residential Group Life Managers (Unabated for 290 Days or More)

[12] Rhonda Wells-Wilbon and Spencer Holland, "Social Learning Theory and the Influence of Male Role Models on African American Children in PROJECT 2000," 6 Qualitative Report 4 (December, 2001).

2 full-time Recreational Specialists (Unabated for 290 Days or More)
1 full-time Maintenance staff

Staffing shortages at Noyes have been consistently reported by the Juvenile Justice Monitoring Unit, beginning with the Quarterly Report for January-March, 2004. Staffing continues to be a major concern at Noyes.

Noyes has a lower percentage of PINs (permanent positions with full benefits) than other facilities. Noyes should have at least 50 PINs for direct care positions (a 2:1 staff:youth ratio). The facility needs about 60 positions to provide consistent coverage, given that leave, training and last minute call outs all diminish the number of staff on duty.

Two additional Residential Group Life Managers are needed. In addition, two full time Recreational Specialists are needed to help ensure that youth receive the recreation required by the Maryland Standards for Juvenile Detention Facilities. These positions should have a PIN assigned, as a contractual position has not attracted potential employees to fill the positions.

Noyes previously had a full time maintenance person, but that employee was moved to Hickey and only attends to Noyes on a periodic basis. Noyes is in need of a permanent full time maintenance person to attend to the many outstanding maintenance requests.

Considerable effort has been made to improve staffing levels, and reportedly there are a number of candidates who will soon be on board. Salaries have been increased to attract and retain employees working in the facility. Additionally, the interviewing and hiring process is being expedited to bring new employees into the facility more quickly.

A new 10-hour 4 day work-week has been initiated at Noyes, and the units are double staffed most of the time. Although staff members still work considerable overtime to maintain staffing levels, they do get a three-day rest. Shifts now have overlapping hours to provide time each week to team meetings.

Two additional Case Managers have been added to deliver services to youth. In spite of these positive changes, however, staff fatigue and burnout is a significant problem at Noyes.

Thomas O'Farrell Youth Center (TOYC)

No issues in this reporting period – staff:youth ratios were found to be acceptable throughout the reporting period..

Sykesville Shelter Care

No issues in this reporting period. Staff to youth ratios were found to be acceptable throughout the reporting quarter. There are two staff members working each shift.

Thomas J.S. Waxter Children's Center (Waxter)

Conditions Requiring Corrective Action

- Staff vacancies (Unabated for 90 Days or More)

The facility continues to be understaffed. Staffing shortages continue to be supplemented with overtime. On November 27, 2006, the facility was down five direct care positions.

Western Maryland Children's Center (WMCC)

Conditions Requiring Corrective Action

- Individual Staff Vacancies/Shortages(Unabated for 30 Days or More)
  - Roving staff (3-11 pm shift)
  - Addictions Counselor
  - Social Worker
  - Case Manager
  - Intake Officer
- Inadequate staff:youth ratios (Unabated for 30 Days or More)

The Monitor has reported staffing problems at WMCC since 2004. Staff shortages are exacerbated by the assignment of WMCC staff to provide coverage at other facilities – in this quarter, at Noyes. (See discussion, p. 14).

In spite of staff shortages, WMCC employees continue to maintain a positive and proactive culture. Youth frequently identify WMCC as the best center where they have been placed. Staff members are described as fair, helpful and respectful to the residents, and other staff members such as cooks, maintenance staff, and teachers help out when they can in providing coverage.

Only one staff is assigned to the two 6 bed pods. When the facility is over its capacity of 24, each 6-bed pod has added up to two youth sleeping on "boats" in the day room. When there is an "all staff duress call" the staff covering a pod must either ignore the call or leave the youth in the day room alone.

The second Addictions Counselor and Social Worker positions have not been filled. Generally one Case Manager for 24 youth is sufficient. Having a second Case Manager at WMCC, however, has been extremely helpful, especially

since the facility is frequently overcrowded. An Intake Officer would also assist in relieving staff of multiple responsibilities.

Youth Centers

Conditions Requiring Corrective Action

- Inadequate staff:youth ratios (Unabated for 30 Days or More)
- Staff shortages (Unabated for 30 Days or More)

The Monitor has expressed concerns about staffing at the Youth Centers since 2003. Once again this quarter, the Youth Centers provided coverage for WMCC which in turn sent three staff members to Noyes. (See discussion, pp. 13-14.) By the end of the reporting period most Youth Center staff had returned to the Centers.

Even with the returning staff, coverage has been problematic at times, especially at Backbone Mountain because new staff members are not certified to be alone with youth and because training and leave affect staffing numbers. Staffing shortages not only affect safety and security, but limit programming. The Youth Centers are "staff secure" programs, but, sometimes on second shift and on weekends, there are only 4 direct care staff members covering 36 to 40 youth.

The other Centers had been sending staff to help at Backbone, but some of the staff called out repeatedly and did not report to Backbone. Experience at The Centers has proven that the old staff:youth target ratio of 1:7 is no longer viable. Each Center actually needs two staff persons for each position in order to maintain adequate coverage. In addition, given the significant transportation needs of the Centers, one additional RA position should be added just to cover transportation.

The Youth Centers have lost 18 positions over the last two years. Frequently when a staff member left the Youth Centers, his/her PIN (Personal Identification Number) was transferred to another facility. Additionally, when contract positions came open, they were not filled.

Recommendations

1. Immediately fill staff vacancies in the following facilities:

    a. BCJJC
    b. Cheltenham
    c. Hickey
    d. MYRC
    e. Noyes
    f. Waxter
    g. WMCC

h. Youth Centers

2. Decrease overtime work among direct care staff to reduce burnout.

3. Increase PINs (permanent positions with benefits) for direct care workers:

   a. Ensure appropriate staff/youth ratios are maintained.
   b. Decrease reliance on contract employees, particularly on agencies providing temporary direct care workers such as nurses.
   c. Give special attention to staffing needs at:

      i BCJJC (including the need for 2 staff in Master Control)
      ii. Carter (including Nurse and Recreation Coordinator)
      iii. Hickey
      iv. MYRC
      v. Noyes (including Nurse, Residential Group Life Managers, Recreation Specialists, and Maintenance staff)
      vi. WMCC
      vii. Youth Centers

4. Streamline the hiring process so that vacancies are filled in a timely fashion.

5. Explore increasing salaries for DJS direct care workers.

6. Ensure that facilities have sufficient staff to allow time for required training.

7. End the practice of shifting staff from their “home” facility to cover shortages at another facility.

8. Increase numbers of male staff (or provide additional opportunities for youth to interact with male role models) at:

   a. LESCC
   b. MYRC

SAFETY AND SECURITY

Overview

Since its inception in 2002, the Juvenile Justice Monitor has reported on a number of safety and security concerns in DJS residential facilities, some of which are potential legal violations. These concerns fall into three major categories:

- Violent/Aggressive Incidents
- Overuse/Improprer Use of Seclusion
- Physical Facility Issues

Violent incidents continue to occur at an alarming rate at some facilities, and some facilities continue to overuse or improperly use seclusion as a common means of behavior control or group management rather than using it sparingly as a *temporary means of protecting a youth who poses an imminent threat to persons or property.*

At the same time, some programs, including secure detention programs, are demonstrating success in reducing both the number of violent incidents and the frequency with which seclusion and/or force are used against youth. At least one secure facility does not use locked door seclusion at all. Programs within DJS facilities that are working to reduce violent incidents should be reviewed and replicated, as appropriate, at other facilities.

In addition to youth-on-youth violence, some children in DJS facilities have been subjected to violence at the hands of staff. It is difficult to gain an accurate count of these incidents, however, because sometimes staff members either provide incomplete information in required reports or fail to report the incidents altogether. In most counties, the agencies responsible for investigating child abuse allegations in DJS facilities – the Maryland State Police, local Departments of Social Services, State's Attorneys offices, and DJS - have no agreed-upon protocol for pursuing the cases.

Finally, this report discusses safety and security issues arising from the poor physical condition of many DJS residential facilities. Several of these facilities have outlived their usefulness as housing units for children, particularly those built to resemble adult jails. While these facilities might be appropriate for other purposes (e.g., day programs or community service centers), as residential facilities they are unsuitable and they threaten the safety of both youth and staff.

The worst physical plants are at Cheltenham, Hickey, Noyes, and Waxter. No repairs or renovations, no matter how extensive, will ever make these facilities appropriate for the housing of youth. We believe that closing these facilities and replacing them with community-based detention and commitment programming options should be a high priority.

Applicable Standards

"(T)he Department shall adopt regulations applicable to residential facilities it operates that…prohibit the use of locked door seclusion and restraints as punishment and describe the circumstances under which locked door seclusion and restraints may be used…" **Md. Code Ann. § 83C, 2-118(c)**

Use of Force

"Use of force is only authorized when necessary, there is imminent danger, and when other lesser alternatives are not suitable or reasonably sufficient.

Staff shall utilize the following levels of intervention prior to any use of force:

a. Attempt to change negative behavior through non-verbal gestures or other signals.
b. Seek to verbally de-escalate the situation in a polite and cordial manner.
c. Attempt to verbally de-escalate the situation in a firm manner, using stronger voice levels and gestures.
d. If possible, a brief (ten to fifteen minute) time out separate a youth from contact with other youth.

All incidents involving the use of force shall, immediately after the incident, be reported to the facility health professional who shall promptly examine the youth.

Every use of force shall be recorded in the appropriate facility and unit logbooks…" **DJS Policy 02.09.13 (2000)**

(T)he Department shall adopt regulations applicable to residential facilities… that… prohibit abuse of a child." **Md. Code Ann. § 83C, 2-118(c).**

Seclusion

"A facility employee may place a youth in locked door seclusion only if:

(a) Clearly necessary to prevent:
  (i) imminent physical harm to the youth or other individuals;
  (ii) imminent and substantial destruction of property; or
  (iii) escape; and
(b) Less restrictive methods of behavior control have failed or cannot reasonably be implemented.

A facility employee shall monitor a youth in locked door seclusion by:

(a) Maintaining auditory contact with the youth at all times;

(b) Making visual contact with the youth every 10 minutes; and
(c) Recording each contact with the youth in a written log book.

In order for a youth to be held in locked door seclusion for longer than 30 minutes during a 12 hour period, the superintendent or the duty officer shall:

(a) Approve the locked door seclusion every 2 hours;
(b) Obtain for the youth an examination by a physician or nurse every 2 hours;
(c) See the youth at least once during each 12-hour period.
(d) Notify the youth's parent if the locked door seclusion continues for more than 8 hours; and
(e) Remove the youth from seclusion after 72 hours, unless a declared written emergency is issued by the superintendent and approved by the Assistant Secretary for Residential Services.

(A) youth shall be released from locked door seclusion when the youth no longer fits the criteria for placement in locked door seclusion."

DJS Policy Number 03.14.04 (2000)

Restraints

"A facility employee may not apply any restraint to a youth as punishment.

A Facility employee may not use restraint in any manner that causes a youth physical pain or undue anxiety.

The superintendent shall ensure that facility staff are trained in the proper use of restraint and that each employee receives such training annually."

DJS Policy Number 03.14.04 (2000)

Staff Behavior

"Every Employee has a responsibility to ensure a safe and humane environment for youth and to respect the individual rights of youth and other clients." **Department of Juvenile Services Standards of Conduct 2.24.2.**

"An employee acting in his or her official capacity may not use any coarse, profane, or insolent language, or take actions towards other employees, supervisors, delinquent youth, offenders, clients or members of the public that is abusive or otherwise considered offensive to contemporary community standards, except as required as part of an approved treatment program." **Department of Juvenile Services Standard of Conduct 2.2.3.**

"Personnel shall be prohibited from the direct or tacit approval of a youth's use of physical force against other youth, or the approval of a youth to exercise authority/control over another youth." **Maryland Standards for Juvenile Detention Facilities 5.4.2.**

Child Abuse Reporting

"Reports submitted by employees shall be clear, concise, factual and accurate." **Department of Juvenile Services Standards of Conduct 2.19.1.**

"To ensure that youth under the care of the Department of Juvenile Services are protected from abuse or neglect, it is required that every employee report any suspected abuse or neglect, both orally and in writing, to the proper authorities." **Department of Juvenile Services Policy 01.01.13.A.**

Physical Plant Security

"In order to obtain and hold a license as a secure care program, a licensee shall…structure the physical plant so that it has:

> (a) A 24-0hour control center for monitoring and coordinating its security, safety, and communication systems,
>
> (b) A perimeter that can retain the children within it and prevent unauthorized access into it, and
>
> (c) Assign and deploy staff so that the children are visually supervised and staff are able to respond immediately to emergencies."

Code of Maryland Regulations (COMAR) 01.04.04.25(B).

"An employee may not take any action or fail to take any action when the action or failure to act causes a breach of security or a potential breach of security…." **Department of Juvenile Services Standards of Conduct 2.13.**

"The licensee shall maintain all structures and grounds in good condition…" **Code of Maryland Regulations (COMAR) 01.04.04.12.C.**

Contraband

"In order to obtain and hold a license as a secure care program, a licensee shall …inspect for contraband, on a daily basis, all areas occupied by the children, document all these inspections, and immediately correct all problems or defects found during the inspections." **Code of Maryland Regulations (COMAR) 01.04.04.26.B.5.**

"An employee shall exercise extreme caution at all times to adequately control weapons… and to prevent delinquent youth from gaining access to them." **Department of Juvenile Services Standards of Conduct 2.15.**

KEY FINDINGS

As would be expected, non-secure facilities have fewer safety and security problems than secure facilities although some concerns are discussed below. Among secure facilities, however, we note significant differences in the number of violent incidents and the frequency with which seclusion and/or force are used against youth.

Several facilities are successfully developing a culture in which there are very few violent or aggressive incidents, and at least one secure facility does not use locked door seclusion at all. This leads us to conclude that it is possible to operate a successful detention or residential treatment program, even in a secure setting, with a minimal number of violent incidents. We attribute these successes, at least in part, to:

a. Sufficient staff training on avoidance of violence and de-escalation of potentially violent situations;
b. A robust behavior management program incorporating meaningful positive incentives for youth;
c. Strong administrative leadership that promotes mutual respect and non-violent resolution of disputes;
d. Close administrative oversight ensuring prompt and full reporting of violent incidents and staff accountability when appropriate.

Child Abuse

In addition to youth-on-youth violence, some children in DJS facilities have been subjected to violence at the hands of staff. Researchers have linked child abuse and delinquency, finding that being abused as a child is one of the best predictors of delinquency or adult criminal activity. A very high percentage of girls involved in the juvenile system have been physically or sexually abused. [13]

It is essential that juvenile residential facilities be as violence-free as possible, and particularly crucial that previously abused and neglected children in these facilities be safe from acts of re-abuse or re-neglect at the hands of adults.

Interagency collaboration in reporting and investigating child abuse or neglect cases is a critical piece of any effort to reduce violence in DJS facilities

[13] See Child Welfare League of America, Child Maltreatment and Juvenile Delinquency: Raising the Level of Awareness, for a summary of research findings.
http://www.cwla.org/programs/juvenilejustice/childmaltreatment.htm

The Maryland State Police (MSP has jurisdiction over all criminal cases in most state facilities)[14], local departments of Social Services and the Maryland Department of Human Resources, State's Attorney offices, and the Department of Juvenile Services must work together to ensure that allegations of child abuse or neglect are vigorously promptly pursued and fully investigated.

Maryland law requires that local agencies develop a written agreement setting out a standard operating procedure for the investigation of child abuse cases.[15] Both DJS and the Monitor have worked to develop written Interagency Agreements to guide the conduct of DJS-related investigations in each county. Unfortunately, to date only Baltimore County has produced such an agreement – it governs investigations at Hickey and GUIDE, the only DJS facilities located in Baltimore County. As of the date of this report, Anne Arundel County is close to finalizing an agreement (controlling actions at Waxter). We urge all involved agencies to finalize these agreements and better collaborate in the reporting and investigation of these cases.

Since 2004, the Monitor has recommended that all DJS and social services investigators and Maryland State Police be trained on proper restraint techniques to improve their ability to assess allegations of child abuse against facility staff. This training has still not been attended by most of the investigators of these agencies.

Physical Facilities

Several of Maryland's physical plants ceased being appropriate housing units for children decades ago. Many of the buildings are dilapidated, and while the facilities might be appropriate for other purposes (e.g., day programs or community service centers), as residential facilities they are completely unsuitable and they threaten the safety of both youth and staff.

Since its inception, the Monitor has recommended numerous facility repairs and renovations throughout the system. Repairs have been exceedingly slow in coming, however, and in many circumstances, have never been made.

Although most facilities need moderate to extensive improvements, the physical plants at Cheltenham, Hickey, Noyes, and Waxter are the worst. The Cheltenham facility is over 130 years old, and in 2001, then-Secretary of Juvenile Services Bishop Robinson pledged to close it for good. Six years later, Cheltenham remains open. Neither Cheltenham nor Waxter has an electronic

[14] The Baltimore City Policy have jurisdiction over Mount Clare, MYRC, and Shaeffer House.
[15] "The local department, the appropriate law enforcement agencies, the State's Attorney within each county and Baltimore City, the local department's office responsible for child care regulation, and the local health officer shall enter into a written agreement that specifies standard operating procedures for the investigation …and prosecution of reported cases of suspected abuse." **Md. Fam. Law Ann. § 5-706(e).**

locking system, and all cells must be opened individually with keys that staff often have difficulty identifying. We believe that closing these facilities and replacing them with community-based detention and commitment programming should be a high priority.

Details on individual facilities follow:

Allegany Girls Group Home (Allegany)

Conditions Requiring Corrective Action

- Access to caustic supplies (Unabated for 30 Days or More)
- Trees blocking the view in the drive should be cleared
- Driveway should be kept clear of snow and ice

The inside door to the garage has been replaced with a solid door to prevent youth access to caustic cleaning supplies stored there. The locks could easily be compromised, however, and the area remains unsecured. Reportedly two sheds will be purchased to provide secure storage for potentially harmful items now stored in the garage.

Overall, the house is in good condition and is well-maintained through cooperation between the Department and the YMCA. The driveway was repaired this fall, but trees still need to be cleared that block the view around the curve in the drive. The driveway also needs to be kept clear of snow and ice.

Baltimore City Juvenile Justice Center (BCJJC)

Conditions Requiring Corrective Action

- Inaccurate reporting of aggressive/violent incidents
- Failure to report and fully investigate child abuse/neglect allegations (Unabated since June, 2004)
- Inaccurate and incomplete documentation of seclusion (Unabated since June, 2006)
- Lack of suicide resistant barrier on second tiers of facility (Unabated since June, 2004)
- Lack of suicide resistant beds (Unabated since June, 2004)

Reports of aggressive incidents of youth on youth assaults, youth on staff assaults and use of force dropped again from 142 last quarter to 127 this quarter (including 19 incidents that were not initially reported as required). According to the DJS Incident Report database, 135 of the 208 incidents (65%) at the facility during the quarter were a result of assaults, use of force or destruction of property.

BCJJC's data may be skewed, however, because it underreported aggressive incidents in this quarter. Incidents that were not reported and/or investigated in a timely manner included an escape, a group altercation, and an assault in which a youth's eye socket was fractured. (For details on BCJJC reporting issues, see Comprehensive Timely Report, 4th Quarter, 2006, pp. 4-6.)

There were three physical child abuse investigations conducted at the facility during this quarter. This monitor was alerted to two of the three incidents through the Baltimore City Public Defender's Office rather than by DJS staff as required. All three of the reports were entered into the system late (up to two weeks), data was often inaccurate and one investigation did not begin until more than 45 days after the incident occurred. When completing required Incident Reports, staff often fail to include any information on injuries sustained.

The process for reporting and investigating child abuse or neglect allegations continue to be inefficient and untimely. Much better coordination among MSP, DSS, and DJS is needed. Baltimore City has not entered into a written interagency agreement for reporting and investigation of child abuse cases.

Reportedly, use of seclusion has been reduced during this quarter. There were 629 incidents of seclusion reported for last quarter and 211 for October and November of this quarter, a significant decrease. According to the DJS Incident Report Database, incidents of youth being placed in locked door seclusion for more than 8 hours declined again from 47 three quarters ago, to 24 two quarters ago, to 8 last quarter, and to 0 this quarter. BCJJC's successful reduction in the number and duration of seclusions should be reviewed by DJS and its practices replicated in facilities that continue to use seclusion as a major means of behavior control.

When youth are secluded, however, BCJJC administration must ensure that staff is properly documenting the seclusion. An examination of several seclusion door sheets revealed numerous inaccuracies, conflicts in observations and incomplete medical checks.

Suicide resistant barriers have been constructed on three of the six units that require the construction. With the exception of one bed on Unit 22, the facility still has no suicide resistant beds. There are exposed holes in the bed frames for potential tie-off risks.

J. Deweese Carter Children's Center (Carter)

Conditions Requiring Corrective Action

- Increase in number of aggressive/violent incidents
- Failure to report and/or investigate violent incidents (Unabated for 30 days or More)

- Lack of gym and recreation space (Unabated for 30 days or more)
- Need for repairs to outdoor basketball court (Unabated for 30 days or more)
- Lack of suicide resistant beds (Unabated for 90 days or more)

Violent incidents have increased at Carter during this quarter. There were 21 reported Use of Force incidents and Youth on Youth Assaults during the 3rd quarter and 29 in this reporting period. There was also one group disturbance resulting in bodily harm or property destruction, one Youth on Staff Assault and one Destruction of Property incident. Thirty-two of the facility's 41 incidents (78%) involved aggressive incidents.

A severe Youth on Youth assault occurred in November, but it was not reported to DJS investigators as required, there was poor collaboration among MSP, CPS and DJS, and the facility administrator failed to initiate the appropriate follow-up actions.

There were 43 seclusions of youth in October, 95 in November and 18 in December. The facility has no suicide resistant beds.

As stated in previous reports, the facility does not have an indoor gymnasium. During inclement weather, the youth are not permitted outside and are often not able to have their required daily large muscle exercise. Youth often slip on the outdoor basketball court because the surface is worn smooth. There is also a six-inch hole directly beneath one of the baskets. The court needs to be resurfaced to prevent injuries.

Cheltenham Youth Facility (CYF)

Conditions Requiring Corrective Action

- Excessive number of aggressive/violent incidents (Unabated for 30 days or More)
- Child abuse allegations
- Inaccurate reporting of aggressive/violent incidents and/or seclusions
- Lack of suicide resistant beds (Unabated for 90 days or More)
- Lack of video surveillance cameras (Unabated for 90 days or More)
- Difficulties with locking system
- Lack of sprinkling system in infirmary
- Failure to make essential repairs to heating system

Aggressive/violent incidents reported included:

68 Youth on Youth Assaults (down from 73 last quarter)
13 Use of Force incidents
7 Destruction of Property incidents
5 Youth on Staff assaults

1 Group Disturbance Resulting in Bodily Harm or Property Destruction
3 reports of Physical Abuse and 1 report of Child Neglect.

There were a total of 98 aggressive incidents out of 244 total incidents (40%) for the quarter. There were 46 seclusions in October and 36 seclusions through November 27.

Several investigations for unnecessary use of force and abuse were completed by DJS. Some of the reports revealed that Prince George's County Department of Social Services failed to accept the cases for investigation as required by law, and one case resulted in staff being charged with unnecessary use of force and failing to seek appropriate medical attention for the youth.

Difficulties with reporting of violent incidents continued in this quarter. Several reports of Locked Door Seclusion were submitted weeks after they occurred, and one report for a Locked Door Seclusion for More than Eight Hours was submitted extremely late and was incomplete. (For details, see Comprehensive Timely Report for Cheltenham at p. 8.)

On November 2, 2006, it was reported that staff had locked down 12 youth in their rooms on October 27 at 4:30 pm for no apparent reason and without obtaining authorization from supervisors (ICAU Number 51397). The staff reportedly left the youth in the care of one staff person while the rest of the staff went to dinner. The report does not indicate whether the youth complained of or were examined for any injuries.

The Nursing Logs for CYF were much more comprehensive and inclusive than the Logs at several other DJS facilities. A review of the Nurses' Logs for October did reveal a few inconsistencies. The Monitor recommended that nurses begin keeping a separate log for youth who are examined due to altercations, use of force allegations, assaults, and the like. This procedure was implemented at CYF.

Accurate reporting is critical to full investigation of violent incidents and to ensuring that youth's rights are being upheld in DJS facilities. We urge DJS headquarters and facility superintendents to create separate Nursing Logs for aggressive/violent incidents in all facilities.

Cheltenham's only suicide resistant beds are located in the infirmary. Because there are no fire sprinklers in the infirmary, we do not believe youth should be sleeping in this part of the facility at all. The effective result is that the facility has no suicide resistant beds available for sleeping.

There are also no video surveillance cameras at CYF. We believe the facility would be well-served by the installation of video surveillance cameras, both

to enhance security and to aid in the investigation of violent incidents, particularly given its high rate of aggressive/violent incidents.

Finally, there was a problem with repair of the boiler on Cornish Cottage this quarter. (See Comprehensive Timely Report for Cheltenham at p. 11 for details.) Although bids for boiler repairs were initially received in April, 2006, they became tied up in state contracting regulations and procedures – ultimately, the boiler had to be completed replaced on an emergency basis during cold weather in December, and all youth housed in the Cottage had to be moved.

We believe that the Department of General Services (DGS) should develop procedures for streamlined and/or expedited purchasing when the items or services needed are essential to the safety or welfare of youth housed in state facilities. Examples of such purchases would be heating equipment, suicide resistant beds, toilet facilities and the like.

GUIDE Structured Shelter Care (GUIDE)

Conditions Requiring Corrective Action

- Excessive number of aggressive/violent incidents (Unabated for 30 days or More)
- Physical plant repairs needed

An alleged sexual abuse occurred on December 26. The administrator advised that the staff member had been suspended from duty pending an investigation by the police, CPS and DJS. Overall, youth interviewed said that they feel safe at the facility and fights between youth are very rare.

Several repairs to the facility are needed. An area for encasing the trash receptacle at the rear of the facility is needed to prevent access to the trash by rodents. The hot water valve in the utility sink in the laundry area continuously leaks, and the dining room window will not remain in an open position. If the window is propped open, the prop could be knocked out and an injury might occur. The facility administrators said that all of the above issues were being addressed.

Charles H. Hickey School (Hickey)

Conditions Requiring Corrective Action

- Excessive number of aggressive/violent incidents (Unabated since 2002)
- High numbers of contraband incidents
- Inaccurate reporting of aggressive/violent incidents and/or seclusions
- Lack of interagency collaboration in reporting and investigation of child abuse cases (Unabated since 2002)
- Physical security issues

A Special Timely Report was completed on October 23, 2006. The report addressed imminent concerns relating to the threat to life, health and safety of the youth at the facility.

The number of aggressive incidents and incidents involving illegal contraband continue to be very high. According to the DJS Incident Report database, although the average monthly population has declined, the average number of aggressive incidents per day remained steady from 1.9 per day during last quarter to 1.8 per day during this quarter. During this quarter, 158 of the 265 incidents (60%) at the facility were assaults, use of force or destruction of property.

There were 16 incidents of illegal contraband in the facility last quarter and 15 incidents this quarter. Homemade shanks made from scissors and nails are secreted within the facility.

Suicidal behaviors, attempts, gestures and ideations have decreased significantly since the third quarter - there were 20 incidents last quarter and 9 in this reporting period.

According to the Master Control Seclusion Log, seclusions were reduced from 74 and 89 incidents in July and August to 67 and 64 incidents in October and November.

Reporting of aggressive/violent incidents continues to be problematic with staff reports either missing or incomplete, and interagency coordination of child abuse investigations is still lacking. In many cases, preliminary evidence appears to support allegations of staff improprieties, but agencies routinely dismiss reports or close them based on statements only. DJS also refused to accept several investigations of neglect because too much time had passed between the incident and the filing of the report.

Several allegations of child abuse at Hickey were investigated by DJS, but the Monitor was not notified as required in the Hickey Interagency Agreement for Investigating Child Abuse and Neglect.

The video monitoring camera outside the infirmary has not been functioning for over six months. The outdoor lighting is not working in several areas of the facility where staff and youth routinely travel by foot. The lights are out at the end of basketball court adjacent to the gatehouse, in the front of the new administration area (old MLK school) and over the vehicle sally port area. Several of the bedroom and dayroom door locks continue to not work properly. Some of the bathroom sinks are clogged, a toilet was not working and there is mold and mildew in shower stalls.

Lower Eastern Shore Children's Center (LESCC)

Conditions Requiring Corrective Action

- Toilet and sink replacement (Unabated since 2002)

According to the DJS Incident Report database, aggressive incidents appear to be down at the facility. There were 37 aggressive incidents last quarter and 20 this quarter. The levels behavior management program may be helping to address some of the aggression in the facility, but of the total of 23 incidents reported at the facility, fully 87% (20 incidents) were assaults, destruction of property, or use of force.

Numbers of seclusions was relatively stable, averaging 14 seclusions per month in the 3rd quarter, 15 in October, 4 in November, and 17 in December (an average of 12 seclusions per month).

DJS has not replaced the vitreous china/porcelain toilets and sinks with stainless steel models. Vitreous china/porcelain fixtures are a safety hazard – they are easily broken off into shards that can be used as weapons or suicide implements.

In January, 2004, DJS agreed to a remediation plan that included:

- Replacement of the vitreous fixtures with stainless steel in no less than two bedrooms immediately;
- Replacement of 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.

Maryland Youth Residence Center (MYRC)

Conditions Requiring Corrective Action

- Second floor bathroom repairs (Unabated since 2004)
- Parking lot lighting (Unabated for 90 Days or More)

Aggressive incidents declined from 17 last quarter to 9 this quarter. Youth on Youth assaults decreased from 11 to 8, and Use of Force incidents decreased from four to one.

Temporary repairs and cosmetic improvements to the second floor bathroom are ongoing; however, permanent repairs to the second floor bathroom

are still needed. Lighting is still needed from the parking lot area of the facility. People without business at the facility have been seen loitering in the parking lot area after dark.

Mount Clare House

The major security issue at Mount Clare concerns DJS' continued referral of severely troubled and sometime dangerous youth to the program. Youth who are inappropriate for the program are repeatedly placed there in spite of administrative objections. In November, one youth was permanently discharged after numerous AWOL's, each usually lasting several days.

All exit doors in the stairwell that were in need of replacement have been replaced. The ceiling in bedroom #5 was cracked and has now been repaired. The air conditioner should be replaced as it is over 25 years old and failed last summer. An estimate of $8,000 has been obtained for a replacement and a contractor selected to install the system. As of yet no time has been set for the installation.

Alfred D. Noyes Children's Center (Noyes)

Conditions Requiring Corrective Action

- Lack of secure and sufficient fencing (Unabated for 30 Days or More)
- Lack of monitoring equipment (both outside and inside the facility) (Unabated for 30 Days or More)
- No announce box at the entrance (Unabated for 30 Days or More)
- Front door and windows not tinted (Unabated for 30 Days or More)
- Monthly fire drills not held (Unabated for 30 Days or More)
- Alarm system malfunctioning repairs (Unabated for 30 Days or More)
- Need for purchase and installation of backup generator (Unabated for 30 Days or More)
- Lack of suicide resistant beds (Unabated since 2005)

The Noyes physical facility is old and presents a number of safety and security challenges that have been consistently reported by JJMU since the Quarterly Report of July-September, 2005. Staffing shortages exacerbate the security problems because regular staff are overworked, making them less able of effectively deescalating situations or dealing with violent incidents.

The number of incidents has declined somewhat from the second quarter average of nearly one incident a day. The third and fourth quarter incident rate has remained about the same as before the spike during the second quarter. Youth on youth assaults have dropped from a high in August of 22, plus a group disturbance, to 8 in December. (See Appendix A, p. ???)

While it is good that aggressive incidents have been reduced, the Monitor is concerned that neither youth nor staff can be assured of their safety at Noyes. The lack of staffing which necessitates overtime and creates burnout, along with inadequate programming all contribute to an unnecessarily stressed environment. (See pp. 15-16 for discussion.)

Lack of fencing security presents a major concern. The fence is obviously vulnerable to being cut from the outside and portions of the exterior of the facility are not fenced at all. Youth report that friends from outside the facility visit at the bedroom windows at night.

Lack of monitoring equipment both outside and inside the facility is also of major concern. Sensors, lighting, cameras, monitors, and recording equipment is lacking and badly needed to enhance the outdoor security of the facility. Hand-held video cameras are available, but they are impractical and inadequate to ensure protection of youth and staff and documentation of incidents and altercations.

There is no announce box at the entrance and the front door and windows are not tinted, presenting both potential security and privacy issues.

Fire drills have not been held monthly as required although by the date of this report they were being held more frequently. The alarm system was also malfunctioning.

At one point during the summer when the local power grid was overwhelmed, Noyes lost power, and with it the air conditioners. A JJMU Monitor was there during that day. The youth were locked down in extremely hot rooms. Noyes has no air conditioner, and does not have a generator sufficient to maintain all functioning of the facility during a power outage.

The beds in the sleeping rooms provide tie off points that in the past have been used by youth to attempt suicide. These beds continue to present a suicide risk. This concern has been raised numerous times and was first reported in the October-December Quarterly Report of 2005.

The gym walls underneath the basketball goals need padding to help prevent injury to youth playing basketball. The request for padding has been made for over a year and was first reported in the JJMU Quarterly Report of October-December 2005. As of the date of this report, the padding for the gym had arrived.

Sykesville Shelter Care

Conditions Requiring Corrective Action

- Driveway repairs (Unabated since March, 2006)

There were no significant concerns involving safety and security; however, there were two AWOL incidents reported at the facility.

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, no repairs were completed as of November 30, 2006.

As of November 30, 2006, a concern with the septic system had been remedied.

Thomas O'Farrell Youth Center (TOYC)

Conditions Requiring Corrective Action

- Excessive number of Youth on Youth assaults (Unabated since 2003)
- Facility renovations needed (Unabated since 2003)
- Improper handling of staff child abuse allegation

According to the DJS Incident Report database, aggressive/violent decreased overall from 36 last quarter to 28 this quarter. Although Use of Force incidents decreased from 20 last quarter to 11 this quarter, Youth on Youth assaults increased from 14 incidents last quarter to 17 incidents this quarter. Youth on Youth assaults remain a concern at the facility.

Several years ago, a TOYC staff person was investigated for child abuse and "indicated." An oral appeal was made to Carroll County DSS, and his "indicated" finding was overturned. This case became a concern again in October when the staff member applied for another position at TOYC.

On October 4, 2006, TOYC administration received a disposition letter from DSS/CPS stating, "Records show [the involved staff] was not named as a person responsible for indicated child abuse or neglect." An internal investigation by TOYC had found that the staff person did use improper force in the incident and a written reprimand was issued. According to the TOYC facility administrator, DJS OPRA conducted an investigation clearing the staff member of any abuse allegation and determining that he could return to work at TOYC.

The Monitor did not receive a copy of any internal DJS reports as required. Proper appeal procedures were also not followed in the case. We recommend

that DJS, DSS, and TOYC conduct a full review of this case before allowing this staff member direct contact with youth.

On December 15, 2006, a freight train carrying hazardous chemicals derailed near the facility and caused an evacuation to a local fire department for several hours. Conversation with staff and members of the fire department revealed that the youth were orderly and respectful throughout their stay at the fire department.

Although numerous repairs have been, or are being completed, the facility is still in need of extensive renovations.

Thomas J.S. Waxter Children's Center (Waxter)

Conditions Requiring Corrective Action

- Excessive number of aggressive/violent incidents (Unabated for 90 Days or More)
- Nursing Log inaccuracies
- Youth on Youth sexual assaults (Unabated for 90 Days or More)
- Failure to properly investigate allegations of sexual assault and child abuse
- Inaccurate/incomplete incident reporting
- Bathroom facilities amount to inhumane treatment (Unabated since 2003)
- Failure to properly discipline staff
- Locking system problematic

The number of aggressive/violent incidents remained stable between the 3rd and 4th quarters but continues to be high. According to the DJS database, there were 35 incidents last quarter and 36 this quarter. Aggressive incidents make up 42% of all incidents at the facility. Waxter labeled an additional 20 incidents as "Youth Requiring On-Grounds Medical Care," and several of those incidents involved youth being injured by other youth during recreation.

There were 33 seclusions in October and 11 through November 25. Several seclusion logs entries failed to indicate when youth had been removed from seclusion.

A check of the nurses' logs revealed there were 15 youth examined in October due to assaults, staff restraints, or other altercations. According to the DJS Incident database, however, in October there were 6 Use of Force incidents, 11 Youth on Youth Assaults and 1 Child Abuse incident that should have resulted in at least 18 youth being examined by nursing staff. The Monitor contacted the DJS Director of Medical Services and recommended that nurses keep a separate log for youth who are examined due to altercations, use of force allegations, assaults, etc.

There were several reports of youth on youth sexual assaults. DJS refused to reopen one of the investigations although an eyewitness was reportedly identified. Another incident was reportedly "videotaped" according to the incident report, but neither of the incidents was reported to the police or DSS.

Overall Incident Reports and injuries due to suspected abuse or neglect are not being appropriately reported or investigated. Many "reports" of these allegations are neither thorough nor comprehensive, and they repeatedly find the allegation "unfounded" without explanation. There is still no interagency agreement for the investigation of abuse and neglect at the facility.

Finally, we continue to be concerned about DJS' failure to hold employees accountable for violent actions against children. In March, 2006, JJMU issued a Special Timely Report for Child Abuse based on an incident at Waxter in which Monitors observed a male staff member attempting to strike a female youth in the face. The staff member was investigated for child abuse and charged by DJS ICAU with violating the DJS Use of Force policy. At the present time, following an Administrative appeal, this staff member, while prohibited from direct youth contact, is working as a Crisis Intervention trainer at Cheltenham.

JJMU strongly believes that DJS should not allow a staff member with a history of violence toward youth in its care to work in any capacity, much less as a Crisis Intervention trainer.

The bathroom facilities in the detention unit continue to be grossly inadequate. The Monitor has cited this concern in 2003. Although the population has decreased dramatically since that time, there are still 20 youth in the detention unit using only two toilets, two sinks and two showers.

Since 2005, administration has reported that five showers and four toilets would be added to the detention unit's bathroom, but installations have not yet occurred. Also Waxter does not have an electronic locking system, and staff are often unable to rapidly locate keys that would be needed to evacuate the building in an emergency.

Western Maryland Children's Center (WMCC)

Safety and security at WMCC is affected by staff shortages, staff fatigue, inexperienced staff, overpopulation, and by the facility fixtures.

Conditions Requiring Corrective Action

- Unsecured control room door (Unabated since April, 2006)
- Failure to secure doors
- Lack of secure and sufficient fencing (Unabated since September, 2004)
- Toilet and sink replacement (Unabated since September, 2002)

The control room door is frequently left open due to poor ventilation of the room. Monitors have even observed the door to the hallway unlocked as youth were passing by the door, and Monitors have seen youth "trying" the door to see whether it was locked. This security breach could result in youth going AWOL or worse. The control room should be equipped with an air conditioner to ensure that security is not compromised.

At times problems with the locking of doors has been observed. Doors that register as locked at times are not secured. The inner doors to the pods are at times left ajar.

The need for additional fencing to secure the outdoor recreation area has been noted in Monitor's reports since September, 2004. In June, 2006 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 allowed the youth to escape, staff have identified several other fencing deficiencies. The Department has not committed to providing the fencing. The fencing deficiencies affect programming as well since youth can not engage in outdoor recreation unless additional staff are available to ensure security.

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.

In January, 2004, DJS agreed to a remediation plan that included:

- Replacement of the vitreous fixtures with stainless steel in no less than two bedrooms immediately;
- Replacement of 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.

Youth Centers

Conditions Requiring Corrective Action

- Passenger vans unsafe (Unabated for 30 Days or More)
- Need for additional vans (Unabated for 30 Days or More)
- Need for small bus

At one time, each Center had four vans, but many were moved to other DJS facilities by Headquarters. The remaining 15-passenger vans were found unsafe by the National Safety Boar. These vans are not equipped with audio or video recording equipments and pose a security risk as well.

Reportedly, each facility is receiving one new 12 passenger van, and the Transportation Office will receive 2 new 12 passenger vans. While sorely needed, one van per Center is inadequate. While an improvement, each Center actually needs four vans to accommodate programmatic needs and emergency transportation needs when required.

The Youth Centers also need a small 18-20 passenger bus to share that would be large enough to transport a group of 12 youth, teachers, and staff for outings and activities.

Recommendations

1. Decrease Youth on Youth Assaults. Particular attention should be given to youth on youth violence at:
   a. Carter
   b. Cheltenham
   c. GUIDE
   c. Hickey
   d. Waxter

2. Reduce cases of excessive use of force and/or child abuse by staff. Particular attention should be paid to this issue at:
   a. Cheltenham
   b. GUIDE
   c. Hickey
   d. TOYC

3. Expand/replicate successful behavior management programs at facilities that are decreasing youth on youth violence, staff use of restraints, and seclusions.

4. Improve staff reporting of aggressive/violent incidents, seclusions, and youth medical exams following incidents. Particular attention should be given to this issue at:
   a. BCJJC
   b. Carter
   c. Cheltenham
   d. Hickey
   e. O'Farrell
   f. Waxter

5. Investigation of child abuse/neglect allegations by all agencies charged with such investigations must be improved. Cases should not be summarily closed without full investigation, and DSS Child Protective Services and the Maryland State Police should not rely on DJS to conduct these investigations.

6. Begin planning to close Cheltenham, Hickey, Noyes, and Waxter as soon as reasonably possible, to be replaced by community-based programs.

7. Make needed facility renovations and installations to prevent suicide:
   a. BCJJC - suicide resistant barriers on second tiers of 3 units;
   b. BCJJC – suicide resistant beds
   c. Carter – suicide resistant beds
   d. CYC – suicide resistant beds
   e. Noyes – suicide resistant beds

8. Improve external security of facilities. Particular attention should be given to:
   a. Allegany (caustic supplies, snow ice, driveway trees)
   b. CYC – video surveillance cameras
   b. Hickey – video monitoring (infirmary), outdoor lights, and door locks
   c. MYRC – parking lot lighting
   b. Noyes – fencing, video monitoring equipment
   c. WMCC - fencing

9. Boilers, heaters, and other equipment designed to provide for the health, safety, and shelter of youth and staff should be given the highest priority for maintenance and service.

10. DJS should work with DGS to establish procedures to expedite purchasing of DJS requests that are essential to the well-being of youth housed in state facilities.

11. Replace vitreous china/porcelain bathroom fixtures
   a. LESCC
   b. WMCC

12. Make needed facility repairs/renovations
   a. Carter (build gym or other recreation space; repair basketball court)
   b. Cheltenham (locking system, lack of fire sprinklers in infirmary)
   c. MYRC (bathroom)
   d. Noyes (backup generator, alarm system)
   e. Sykesville (driveway)
   f. TOYC (2nd floor bathroom, exterior lighting, general)
   g. Waxter (bathrooms, locking system)

13. Improve internal security practices at WMCC.
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14. Provide Youth Centers with appropriate and safe transportation

OTHER ISSUES

Conditions Requiring Corrective Action

- Lack of Commitment Care Standards (Unabated since 2004)
- Requiring that Monitors be Escorted on Visits (Unabated for 200 days or More)

Commitment Care Standards

In 2004 the Monitor first expressed concern about DJS' lack of standards to guide its commitment care programs. Commitment care is provided at 12 state facilities (including Allegany, Mount Clare, Sykesville, Thomas O'Farrell, Waxter, and the 7 Youth Centers) as well as a host of private facilities licensed by DJS.

Currently these programs operate under an awkward set of Directives from the Secretary and procedural manuals developed in-house. More than 1,000 youth are placed in commitment care programs in the state of Maryland each year – it is essential that standards governing the operation of these programs be developed immediately.

A stop-gap measure might be to adopt a set of standards developed by one of the juvenile justice professional associations to be replaced with unique standards for the state of Maryland at a later date.

Monitor Escorts

The Standard Operating Procedure agreed to between DJS and JJMU (2002) clearly states Monitors should not be escorted through facilities or any way impeded in their investigations of conditions. Nevertheless, DJS facilities are inconsistent in adhering to this policy.

BCJJC continues to require that facility staff escort Monitors, and more recently Hickey has also begun using escorts. This practice compromises the Monitor's ability to gather crucial information, and staff interviewed say that the effect of the practice is to inhibit staff and youth from divulging any information that might reflect poorly on DJS.

DJS administration should clarify the "no escort" rule with all facility superintendents.

Recommendations

1. DJS should immediately promulgate commitment care standards. If this is not possible, it should temporarily adopt standards developed a juvenile

justice professional association, to be followed with unique Maryland standards at a later time.

2. Facilities should cease the practice of requiring escorts on Monitor visits and DJS Headquarters should ensure that the policy is communicated to all facility superintendents.

SUMMARY OF RECOMMENDATIONS FOR 4TH QUARTER, 2006

Detention and Pending Placement Periods

1. The Department should conduct its own special review of the cases of all youth who have been in either detention or pending placement for more than 60 days to ensure that their cases are being processed in a timely manner.

2. DJS should immediately develop separate standards for "pending placement" youth.

3. The Department should complete the Confinement Review study begun in 2006 to uncover the reasons for lengthy or inappropriate detention and pending placement periods. All potential causes of delay, including ineffective confinement review or case management practices, scarce facilities/programs, attorney waivers, court practices, and/or out-of-state placement issues should be explored.

4. Current practices that result in lengthy detention and/or pending placement confinements should be replaced with processes that move children out of detention and pending placement as quickly as possible.

5. Confinement review programs at facilities that have successfully reduced detention and pending placement periods should be replicated at other facilities.

6. The Department should expand the Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative (now being piloted at the Baltimore City Juvenile Justice Center [BCJJC]) to reduce the time youth spend in detention and pending placement.

Staffing

1. Immediately fill staff vacancies in the following facilities:

    a. BCJJC
    b. Cheltenham
    c. Hickey
    d. MYRC
    e. Noyes
    f. Waxter
    g. WMCC

h. Youth Centers

2. Decrease overtime work among direct care staff to reduce burnout.

3. Increase PINs (permanent positions with benefits) for direct care workers:

   a. Ensure appropriate staff/youth ratios are maintained.
   b. Decrease reliance on contract employees, particularly on agencies providing temporary direct care workers such as nurses.
   c. Give special attention to staffing needs at:

      i BCJJC (including the need for 2 staff in Master Control)
      ii. Carter (including Nurse and Recreation Coordinator)
      iii. Hickey
      iv. MYRC
      v. Noyes
      vi. WMCC
      vii. Youth Centers

4. Streamline the hiring process so that vacancies are filled in a timely fashion.

5. Explore increasing salaries for DJS direct care workers.

6. Ensure that facilities have sufficient staff to allow time for required training.

7. End the practice of shifting staff from their “home” facility to cover shortages at another facility.

8. Increase numbers of male staff (or provide additional opportunities for youth to interact with male role models) at:

   a. LESCC
   b. MYRC

Safety and Security

1. Decrease Youth on Youth Assaults. Particular attention should be given to youth on youth violence at:
   a. Carter
   b. Cheltenham
   c. GUIDE
   c. Hickey
   d. Waxter

2. Reduce cases of excessive use of force and/or child abuse by staff. Particular attention should be paid to this issue at:

a. Cheltenham
b. GUIDE
c. Hickey
d. TOYC

3. Expand/replicate successful behavior management programs at facilities that are decreasing youth on youth violence, staff use of restraints, and seclusions.

4. Improve staff reporting of aggressive/violent incidents, seclusions, and youth medical exams following incidents. Particular attention should be given to this issue at:
   a. BCJJC
   b. Carter
   c. Cheltenham
   d. Hickey
   e. O'Farrell
   f. Waxter

5. Investigation of child abuse/neglect allegations by all agencies charged with such investigations must be improved. Cases should not be summarily closed without full investigation, and DSS Child Protective Services and the Maryland State Police should not rely on DJS to conduct these investigations.

6. Begin planning to close Cheltenham, Hickey, Noyes, and Waxter as soon as reasonably possible, to be replaced by community-based programs.

7. Make needed facility renovations and installations to prevent suicide:
   a. BCJJC - suicide resistant barriers on second tiers of 3 units;
   b. BCJJC – suicide resistant beds
   c. Carter – suicide resistant beds
   d. CYC – suicide resistant beds
   e. Noyes – suicide resistant beds

8. Improve external security of facilities. Particular attention should be given to:
   a. Allegany (caustic supplies, snow ice, driveway trees)
   b. CYC – video surveillance cameras
   b. Hickey – video monitoring (infirmary), outdoor lights, door locks
   c. MYRC – parking lot lighting
   b. Noyes – fencing, video monitoring equipment
   c. WMCC - fencing

9. Boilers, heaters, and other equipment designed to provide for the health, safety, and shelter of youth and staff should be given the highest priority for maintenance and service.

10. DJS should work with DGS to establish procedures to expedite purchasing of DJS requests that are essential to the well-being of youth housed in state facilities.

11. Replace vitreous china/porcelain bathroom fixtures
    a. LESCC
    b. WMCC

12. Make needed facility repairs/renovations
    a. Carter (build gym or other recreation space; repair basketball court)
    b. Cheltenham (locking system, lack of fire sprinklers in infirmary)
    c. MYRC (bathroom)
    d. Noyes (backup generator, alarm system)
    e. Sykesville (driveway)
    f. TOYC (2nd floor bathroom, exterior lighting, general)
    g. Waxter (bathrooms, locking system)

13. Improve internal security practices at WMCC.
.
14. Provide Youth Centers with appropriate and safe transportation

Other

1. Promulgate commitment care standards immediately. If this is not possible, DJS should temporarily adopt standards developed a juvenile justice professional association, to be followed with unique Maryland standards at a later time.

2. Facilities should cease the practice of requiring escorts on Monitor visits and ensure that the policy is communicated to all facility superintendents.

SUMMARY OF CONDITIONS REQUIRING CORRECTIVE ACTION INCLUDING CONDITIONS REMAINING UNABATED FOR 30 DAYS OR MORE 4TH QUARTER, 2006

Detention and Pending Placement

Conditions Requiring Corrective Action

- Failure to observe legal limits on detention periods (throughout system)
- Failure to develop standards governing care of "pending placement" youth (throughout system)

Staffing

Allegany Girls Group Home (Allegany)

No issues in this reporting period.

Baltimore City Juvenile Justice Center (BCJJC)

Conditions Requiring Corrective Action

- Inadequate staff/youth ratios (Unabated for 90 Days or More)
- Excessive use of overtime to meet staffing ratios (Unabated for 90 Days or More)
- Inadequate staffing of Master Control (Unabated for 90 days or More)

J. Deweese Carter Children's Center (Carter)

Conditions Requiring Corrective Action

- Inadequate number of staff positions
  - Nurse (evening shift)
  - Recreation Coordinator

Cheltenham Youth Facility (CYF)

Conditions Requiring Corrective Action

- Staff vacancies (Unabated for 90 Days or More)
- Excessive use of overtime to meet staffing ratios

GUIDE Structured Shelter Care (GUIDE)

No issues in this reporting period.

Charles H. Hickey School (Hickey)

Conditions Requiring Corrective Action

Lower Eastern Shore Children's Center (LESCC)

Conditions Requiring Corrective Action

- Staff vacancies (Unabated for 30 Days or More)
- Excessive use of overtime to meet staffing ratios
- Inadequate numbers of male staff or male role models (Unabated for 90 Days or More)

Maryland Youth Residence Center (MYRC)

Conditions Requiring Corrective Action

- Inadequate staff/youth ratios (Unabated for 290 Days or More)
- Inadequate numbers of male staff or male role models (Unabated for 90 Days or More)

Mount Clare House

No issues in this reporting period.

Alfred D. Noyes Children's Center (Noyes)

Conditions Requiring Corrective Action

- Inadequate permanent (PINS) positions (Unabated for 290 Days or More)
- Inadequate staff/youth ratio (Unabated for 290 Days or More)
- Staff vacancies
  - 2 full-time Residential Group Life Managers (Unabated for 290 Days or More)
  - 2 full-time Recreational Specialists (Unabated for 290 Days or More)
  - 1 full-time Maintenance staff

Thomas O'Farrell Youth Center (TOYC)

No issues in this reporting period.

Sykesville Shelter Care

No issues in this reporting period.

Thomas J.S. Waxter Children's Center (Waxter)

Conditions Requiring Corrective Action

- Staff vacancies (Unabated for 90 Days or More)

Western Maryland Children's Center (WMCC)

Conditions Requiring Corrective Action

- Individual Staff Vacancies/Shortages (Unabated for 30 Days or More)
  - Roving staff (3-11 pm shift)
  - Addictions Counselor
  - Social Worker
  - Case Manager
  - Intake Officer
- Inadequate staff:youth ratios (Unabated for 30 Days or More)

Youth Centers

Conditions Requiring Corrective Action

- Inadequate staff:youth ratios (Unabated for 30 Days or More)
- Staff shortages (Unabated for 30 Days or More)

Safety and Security

Allegany Girls Group Home (Allegany)

Conditions Requiring Corrective Action

- Access to caustic supplies (Unabated for 30 Days or More)
- Trees blocking the view in the drive should be cleared
- Driveway should be kept clear of snow and ice

Baltimore City Juvenile Justice Center (BCJJC)

Conditions Requiring Corrective Action

- Inaccurate reporting of aggressive/violent incidents

- Failure to report and fully investigate child abuse/neglect allegations (Unabated since June, 2004)
- Inaccurate and incomplete documentation of seclusion (Unabated since June, 2006)
- Lack of suicide resistant barrier on second tiers of facility (Unabated since June, 2004)
- Lack of suicide resistant beds (Unabated since June, 2004)

J. Deweese Carter Children's Center (Carter)

Conditions Requiring Corrective Action

- Increase in number of aggressive/violent incidents
- Failure to report and/or investigate violent incidents (Unabated for 30 days or More)
- Lack of gym and recreation space (Unabated for 30 days or more)
- Need for repairs to outdoor basketball court (Unabated for 30 days or more)
- Lack of suicide resistant beds (Unabated for 90 days or more)

Cheltenham Youth Facility (CYF)

Conditions Requiring Corrective Action

- Excessive number of aggressive/violent incidents (Unabated for 30 days or More)
- Child abuse allegations
- Inaccurate reporting of aggressive/violent incidents and/or seclusions
- Lack of suicide resistant beds (Unabated for 90 days or More)
- Lack of video surveillance cameras (Unabated for 90 days or More)
- Failure to make essential repairs to heating system
- Difficulties with locking system
- Lack of sprinkling system in infirmary

GUIDE Structured Shelter Care (GUIDE)

Conditions Requiring Corrective Action

- Excessive number of aggressive/violent incidents (Unabated for 30 days or More)
- Physical plant repairs needed

Charles H. Hickey School (Hickey)

Conditions Requiring Corrective Action

- Excessive number of aggressive/violent incidents (Unabated since 2002)
- High numbers of contraband incidents
- Inaccurate reporting of aggressive/violent incidents and/or seclusions
- Lack of interagency collaboration in reporting and investigation of child abuse cases (Unabated since 2002)
- Physical security issues

Lower Eastern Shore Children's Center (LESCC)

Conditions Requiring Corrective Action

- Toilet and sink replacement (Unabated since 2002)

Maryland Youth Residence Center (MYRC)

Conditions Requiring Corrective Action

- Second floor bathroom repairs (Unabated since 2004)
- Parking lot lighting (Unabated for 90 Days or More)

Mount Clare House

No issues in this reporting period.

Alfred D. Noyes Children's Center (Noyes)

Conditions Requiring Corrective Action

- Lack of secure and sufficient fencing (Unabated for 30 Days or More)
- Lack of monitoring equipment (both outside and inside the facility) (Unabated for 30 Days or More)
- No announce box at the entrance (Unabated for 30 Days or More)
- Front door and windows not tinted (Unabated for 30 Days or More)
- Monthly fire drills not held (Unabated for 30 Days or More)
- Alarm system malfunctioning repairs (Unabated for 30 Days or More)
- Need for purchase and installation of backup generator (Unabated for 30 Days or More)
- Lack of suicide resistant beds (Unabated since 2005)

Sykesville Shelter Care

Conditions Requiring Corrective Action

- Driveway repairs (Unabated since March, 2006)

Thomas O'Farrell Youth Center (TOYC)

Conditions Requiring Corrective Action

- Excessive number of Youth on Youth assaults (Unabated since 2003)
- Facility renovations needed (Unabated since 2003)
- Improper handling of staff child abuse allegation

Thomas J.S. Waxter Children's Center (Waxter)

Conditions Requiring Corrective Action

- Excessive number of aggressive/violent incidents (Unabated for 90 Days or More)
- Nursing Log inaccuracies
- Youth on Youth sexual assaults (Unabated for 90 Days or More)
- Failure to properly investigate allegations of sexual assault and child abuse
- Inaccurate/incomplete incident reporting
- Bathroom facilities amount to inhumane treatment (Unabated since 2003)
- Failure to properly discipline staff
- Difficulties with locking system

Western Maryland Children's Center (WMCC)

Conditions Requiring Corrective Action

- Unsecured control room door (Unabated since April, 2006)
- Failure to secure doors
- Lack of secure and sufficient fencing (Unabated since September, 2004)
- Toilet and sink replacement (Unabated since September, 2002)

Youth Centers

Conditions Requiring Corrective Action

- Passenger vans unsafe (Unabated for 30 Days or More)
- Need for additional vans (Unabated for 30 Days or More)
- Need for small bus