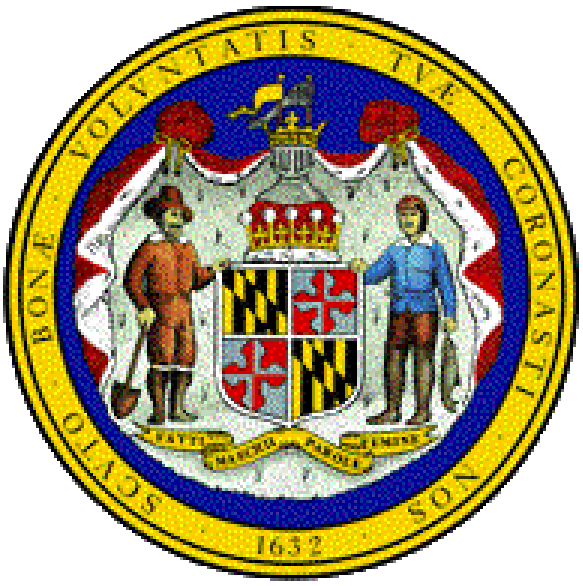

JUVENILE JUSTICE MONITORING UNIT

OFFICE OF THE ATTORNEY GENERAL

SECOND QUARTER 2013 REPORT

NICK MORONEY
Director

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

August 9, 2013

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

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

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

Ms. Anne Sheridan, Executive Director
Governor's Office for Children, Office of the Governor
301 W. Preston Street, Suite 1502
Baltimore, MD 21201

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

Dear Mr. President, Mr. Speaker, Sec. Abed, Ms. Sheridan, and State Advisory Board Members:

Enclosed please find the most recent Quarterly Report from the Juvenile Justice Monitoring Unit (JJMU) at the Office of the Attorney General. The report covers the Second Quarter of 2013, from April 1 to June 30, 2013. The Department of Juvenile Services (DJS) Response is included as part of the present document.

I would be pleased to answer any questions you may have about this report. I can be reached by email at nmoroney@oag.state.md.us and by phone at 410-576-6599 (o) or 410-952-1986 (c). All current and prior reports of the Juvenile Justice Monitoring Unit are available through our website at www.oag.state.md.us/jjmu.

I look forward to continuing to work with you to enhance programs and services provided to the youth of Maryland.

Respectfully submitted,

Nick Moroney

Nick Moroney
Director
Juvenile Justice Monitoring Unit

Cc: The Honorable James Brochin, Maryland State Senate
The Honorable Joan Carter Conway, Maryland State Senate
The Honorable Brian Frosh, Maryland State Senate
The Honorable Lisa Gladden, Maryland State Senate
The Honorable Nancy Jacobs, Maryland State Senate
The Honorable Edward Kasemeyer, Maryland State Senate
The Honorable Delores Kelley, Maryland State Senate
The Honorable Nancy King, Maryland State Senate
The Honorable James Mathias, Maryland State Senate
The Honorable C. Anthony Muse, Maryland State Senate
The Honorable Victor Ramirez, Maryland State Senate
The Honorable Robert A. Zirkin, Maryland State Senate
The Honorable Norman Conway, Maryland House of Delegates
The Honorable Kathleen Dumais, Maryland House of Delegates
The Honorable Adelaide Eckardt, Maryland House of Delegates
The Honorable Ana Sol Gutierrez, Maryland House of Delegates
The Honorable Susan Lee, Maryland House of Delegates
The Honorable Anthony J. O'Donnell, Maryland House of Delegates
The Honorable Samuel Rosenburg, Maryland House of Delegates
The Honorable Luiz Simmons, Maryland House of Delegates
The Honorable Nancy Stocksdale, Maryland House of Delegates
The Honorable Joseph Vallario, Maryland House of Delegates
The Honorable Jeff Waldstreicher, Maryland House of Delegates
The Honorable Nancy Kopp, Treasurer's Office
The Honorable Katherine Winfree, Chief Deputy Attorney General

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Linda McWilliams, Karl Pothier and Jay Cleary, DJS

JUVENILE JUSTICE MONITORING UNIT - SECOND QUARTER 2013

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SECOND QUARTER 2013 - OVERVIEW

Progress continues in the protection from harm and provision of appropriate services to Maryland's most vulnerable and challenged youth. Second Quarter 2013 reports indicated:

- ✓ The average daily population at the Baltimore City (BCJJC) and Baltimore County (Hickey school) juvenile detention centers declined by 24% and 25% compared with the same period in 2012. The number of youth who spent more than 60 days in detention before transfer to a treatment program from Cheltenham (Prince George's County), BCJJC and the Hickey School decreased by 81%, 71% and 70% respectively.
- ✓ Incidents involving aggression decreased significantly at the Meadow Mountain treatment facility and at the Cheltenham, Lower Eastern Shore Children's Center and Noyes detention centers compared to the second quarter of 2012. Incidents remained low at the Carter treatment center for girls and the western Maryland detention center for boys (WMCC).
- ✓ Incidents involving physical restraint decreased by 36% during the second quarter of 2013 (compared with the same period last year) at the Waxter detention center for girls in Laurel. Incidents involving the use of seclusion remained low at Waxter, Noyes (detention center in Montgomery County), Carter, CYF, LESCC and WMCC.
- ✓ The Maryland State Department of Education (MSDE) is now responsible for delivering education services to youth in all DJS operated facilities.

Reports also indicated:

- Incidents involving aggression increased at the Hickey School detention center. Incidents also increased at the Savage Mountain treatment center in western Maryland.

- Overcrowding persists at the CYF, LESCC and WMCC detention centers.

1. Population: Alternatives to Detention and Pending Placement

FACILITY	DJS-Set Capacity	High Population Q2 2012/2013	Low Population Q2 2012/2013	Average Population Q2 2012/2013	Days Over Capacity Q2 2012/2013
BCJJC	120	123/97	85/66	110/84	4/0
CYF	115	125/116	85/77	105/98	13/3
HICKEY	72	86/79[1]	43/34	71/53	47/13
LESCC	24	29/26	21/16	27/22	84/10
NOYES	57	63/48	37/30	51/42	21/0
WAXTER	42	42/33	25/23	34/29	4/0
WMCC	24	30/29	16/19	24/24	47/38

During the second quarter of 2013, the average daily population (ADP) at BCJJC and at Hickey declined by 24% and 25% compared with the same period in 2012. The reduction was driven in part by the Department's partnership with the Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative (JDAI) in Baltimore City. JDAI promotes the appropriate use of alternatives to secure detention. The JDAI effort in Baltimore is ongoing and should continue.

Declines in average daily population in detention centers are also attributable to the Department's successful efforts to reduce the number of pending placement status youth stuck in detention. Pending placement refers to the status of youth waiting in detention centers for a slot to become available in a court-ordered program. During the second quarter of 2013, the number of youth who spent more than 60 days pending placement at Cheltenham, BCJJC and Hickey decreased by 81%, 71% and 70% compared to the same period last year.

[1] The days on which Hickey exceeded its rated capacity occurred when a physical plant problem at Cheltenham required the temporary closure of a living unit there and a relocation of youth to Hickey.

Despite reductions in the number of pending placement youth at Cheltenham, the average daily population at CYF declined just 6%. Increasing detention status youth caused overcrowding.

SECOND QUARTER (April 1 to June 30)	TOTAL YOUTH ENTRIES	PENDING PLACEMENT STATUS ENTRIES	DETENTION STATUS ENTRIES
2013	638	149	489
2012	604	188	416
2011	652	169	403

The chart above shows that the total number of youth entries and pending placement status entries to CYF have decreased while detention status youth entries have increased. The result of increasing detention status entries to CYF is overcrowding, as indicated in the chart below.

CYF BY UNIT on June 30, 2013	YOUTH COUNT	DJS RATED CAPACITY
Rennie Cottage	**43 (+79%)**	**24**
Henry Cottage	**38 (+58%)**	**24**
Cornish Cottage	**28 (+17%)**	**24**
Infirmary	**7**	**14**
Re-Direct (closed 2010)	**0**	**24**
Shelter Care Program (closed 2010)	**0**	**5**
Total Youth	**116**	**115**

The JDAI effort launched in Prince George's County during the first quarter of 2013 should continue in order to limit the use of secure detention whenever appropriate and relieve crowded conditions at CYF.

Smaller DJS detention facilities also remain pressured by daily population levels. In order to ensure the utilization of alternatives to secure detention in all appropriate cases, JDAI should be launched statewide.

2. Reducing Violence

During the second quarter of 2013, incidents declined at some of the larger DJS operated detention facilities, including the Cheltenham Youth Facility (CYF) in Prince George's County and the Alfred D. Noyes Children's Center in Montgomery County. Reported incidents also declined dramatically at Meadow Mountain treatment center in western Maryland.

Incidents remained low at smaller DJS operated facilities including Lower Eastern Shore Children's Center and Western Maryland Children's Center (detention centers) and the Carter treatment center on the eastern shore.

Incidents at Baltimore City Juvenile Justice Center (BCJJC)

The average daily population at the Baltimore City juvenile detention center (BCJJC) declined by 24% while youth on youth assaults declined by approximately 10% and the number of injuries associated with such incidents did not decrease.

BCJJC - SELECTED INCIDENT CATEGORIES	Q2 2012	Q2 2013
1. Youth on Youth Assault	79	71
2. Youth on Youth Assault – Injury Associated*	44	45
3. Youth on Staff Assault	4	3
4. Alleged Youth on Staff Assault – Injury Associated*	3	0
5. Group Disturbances (injury/destruction associated*)	3	4
6. Group Disturbances (without injury/destruction)	0	1
7. Seclusions Over 8 Hours	0	1
8. Restraints	106	104
9. Restraints with handcuffs	27	34
10. Restraints with Injury Associated*	51	44
11. Contraband	6	4
12. Suicide Ideation, Gesture, Attempt or Behavior	6	4

*Injury Associated includes injury to youth and/or staff just prior to, during, or resulting from an incident.

Total incidents for BCJJC declined by 16%. Incidents involving injury were down to 84 from 111 during the same period in 2012. Seclusions under eight hours decreased

by 28% from 94 to 68 instances. The number of incidents involving the use of physical restraints remains high and incidents involving the use of mechanical restraints increased by 26%.

Incidents at the Charles H. Hickey, Jr., School (Hickey)

Incidents at the Charles H. Hickey, Jr. School (Baltimore County detention center) increased while the average daily population decreased by 25%.

HICKEY - SELECTED INCIDENT CATEGORIES	Q2 2012	Q2 2013
1. Youth on Youth Assault	35	47
2. Youth on Youth Assault – Injury Associated*	13	22
3. Youth on Staff Assault	6	5
4. Alleged Youth on Staff Assault – Injury Associated*	1	1
5. Group Disturbances (injury/destruction associated*)	1	5
6. Group Disturbances (without injury/destruction)	1	0
7. Seclusions Over 8 Hours	0	0
8. Restraints	65	101
9. Restraints with handcuffs	5	9
10. Restraints with Injury Associated*	20	25
11. Contraband	2	2
12. Suicide Ideation, Gesture, Attempt or Behavior	9	13

*Injury Associated includes injury to youth and/or staff just prior to, during, or resulting from an incident.

A total of 269 incidents (including sports related injuries) were reported for Hickey in the second quarter of 2013 versus 188 in the same period in 2012. Incidents involving injury numbered 181 (including sports related injuries) during the second quarter of 2013 versus 87 during the same period in 2012.

Youth on youth physical assaults and restraints increased by approximately 34% and 55% over the same period. Group disturbances with injury and/or property destruction increased from one to five. The use of seclusions under eight hours increased from 11 to 22 instances.

An incident during the second quarter involved an inappropriate restraint and incomplete reporting and reviewing by Hickey staff.[2] Video footage shows a staffer restraining a youth from behind, lifting him up and dropping him to the concrete. The child sustained abrasions to the side of his face, shoulder and knee (DJS IR 112188).

The incident was reviewed by the shift commander and an administrator's designee however, neither Baltimore County Child Protective Services (CPS) nor facility administrators were made aware of the circumstances of the incident until four days later when the involved youth told an assistant superintendent about the restraint. The staffer involved in the restraint was ultimately indicated for child abuse by CPS.

Incidents at Cheltenham Youth Facility (CYF)

Incidents declined at the Cheltenham Youth Facility (detention center in Prince George's County). While the average daily population at CYF declined 6% (comparing second quarter of 2013 to the same period last year), youth on youth assaults decreased by 37%; incidents involving the use of physical restraints declined by 20%; and use of seclusions under eight hours decreased from 17 to 4 instances.

CYF - SELECTED INCIDENT CATEGORIES	Q2 2012	Q2 2013
1. Youth on Youth Assault	76	48
2. Youth on Youth Assault – Injury Associated*	36	8
3. Youth on Staff Assault	8	6
4. Alleged Youth on Staff Assault – Injury Associated*	2	1
5. Group Disturbances (injury/destruction associated*)	5	2
6. Group Disturbances (without injury/destruction)	1	1
7. Seclusions Over 8 Hours	0	0
8. Restraints	111	88
9. Restraints with handcuffs	8	3
10. Restraints with Injury Associated*	33	11
11. Contraband	3	6
12. Suicide Ideation, Gesture, Attempt or Behavior	21	7

*Injury Associated includes injury to youth and/or staff just prior to, during, or resulting from an incident.

[2] Similar concerns regarding the Hickey School were documented in the JJMU first quarter report for 2013. That report can be accessed here: http://www.oag.state.md.us/JJMU/reports/13_Quarter1.pdf

Total incidents (including sports related injuries) reported for CYF in the second quarter of 2013 were 141 versus 229 during the same time in 2012. There were 25 incidents involving injury during the second quarter of 2013 compared with 85 during the same period in 2012.

There was an incident at Cheltenham involving a physical restraint of a youth after which CYF medical reported that the youth was not responsive (DJS IR 111702 on June 6). The youth remained unresponsive until after he was transported to the emergency room of a local hospital. Facility management conducted a review and the DJS-OIG investigated the circumstances surrounding the incident. The investigative report is close to completion (as of time of writing [July 15]).

Incidents at the Thomas J. S. Waxter Children's Center (Waxter)

There was a 15% decrease in average daily population during the second quarter at the Waxter detention center for girls. Youth on youth assaults were up 47% however, injuries associated with assaults among youth declined 66%

WAXTER - SELECTED INCIDENT CATEGORIES	Q2 2012	Q2 2013
1. Youth on Youth Assault	17	25
2. Youth on Youth Assault – Injury Associated*	6	2
3. Youth on Staff Assault	5	3
4. Alleged Youth on Staff Assault – Injury Associated*	2	0
5. Group Disturbances (injury/destruction associated*)	1	1
6. Group Disturbances (without injury/destruction)	0	3
7. Seclusions Over 8 Hours	0	0
8. Restraints	53	34
9. Restraints with handcuffs	4	1
10. Restraints with Injury Associated*	15	1
11. Contraband	1	3
12. Suicide Ideation, Gesture, Attempt or Behavior	32	19

*Injury Associated includes injury to youth and/or staff just prior to, during, or resulting from an incident.

Youth on staff assaults were also down and the number of physical restraints declined by 36%. Injuries associated with physical restraints declined 93%. The use of seclusions under eight hours remained low.

Total incidents (including sports related injuries) reported for Waxter decreased nearly 40% from 157 in the second quarter of 2012 to 96 in the same period this year. Incidents involving injury decreased from 51 to 26.

Incidents at the Victor Cullen Center (Victor Cullen)

The average daily population at the Victor Cullen hardware secure treatment facility for boys increased by 4% during the second quarter of 2013 compared with the same period last year.

The number of youth on youth assaults increased by 35% however, the number of injuries associated with assaults among youth decreased 75%.

VICTOR CULLEN - SELECTED INCIDENT CATEGORIES	Q2 2012	Q2 2013
1. Youth on Youth Assault	20	27
2. Youth on Youth Assault – Injury Associated*	4	1
3. Youth on Staff Assault	9	8
4. Alleged Youth on Staff Assault – Injury Associated*	0	1
5. Group Disturbances (injury/destruction associated*)	0	0
6. Group Disturbances (without injury/destruction)	0	0
7. Seclusions Over 8 Hours	0	0
8. Restraints	61	77
9. Restraints with handcuffs	43	42
10. Restraints with Injury Associated*	2	6
11. Contraband	2	8
12. Suicide Ideation, Gesture, Attempt or Behavior	6	1

*Injury Associated includes injury to youth and/or staff just prior to, during, or resulting from an incident.

Total incidents (including sports related injuries) reported for Victor Cullen in the second quarter of 2013 were 116, up slightly from 110 in the same period last year. There were 22 incidents involving injury during the first quarter in both 2012 and 2013.

The number of physical restraints increased by 26%. The use of handcuffs during physical restraints remained high. Seclusions under eight hours doubled from 17 to 34.

A significant proportion of aggressive incidents involve youth transferred from other programs. An intensive orientation process for all youth entering the program should be developed at Victor Cullen, and the three vacancies for mental health staff should be filled as soon as possible in order to effectively address the needs of up to 48 youth.

Incidents at the four youth treatment centers in western Maryland

There were small decreases in average daily population at the Green Ridge (-2.5%), Meadow Mountain (-5%) and Savage Mountain (-2.7%) youth treatment centers. The average daily population at Backbone Mountain youth treatment center decreased by 29% as a result of Department action following an increase in incidents.

YOUTH CENTERS - SELECTED INCIDENT CATEGORIES (combined totals from all four centers)	Q2 2012	Q2 2013
1. Youth on Youth Assault	49	41
2. Youth on Youth Assault – Injury Associated*	22	29
3. Youth on Staff Assault	5	10
4. Alleged Youth on Staff Assault – Injury Associated*	0	5
5. Group Disturbances (injury/destruction associated*)	0	1
6. Group Disturbances (without injury/destruction)	0	1
7. Seclusions Over 8 Hours	0	0
8. Restraints	66	84
9. Restraints with handcuffs	16	29
10. Restraints with Injury Associated*	20	38
11. Contraband	12	15
12. Suicide Ideation, Gesture, Attempt or Behavior	4	3

*Injury Associated includes injury to youth and/or staff just prior to, during, or resulting from an incident.

Total incidents at the centers (including sports related injuries) were 166, up slightly from 164 during the same period last year. Incidents involving injury increased

from 48 to 64. An intensive orientation process for all youth entering the program should be developed at each of the four youth centers.

While youth on youth assaults decreased from 23 to 9 at Meadow Mountain, they increased from 8 to 19 at Savage Mountain. Similarly, injuries associated with assaults among youth were down from 8 to 1 at Meadow Mountain, and up from 6 to 19 at Savage Mountain.

The use of physical restraints by staff on youth increased at Savage Mountain from 10 to 28 and at Backbone Mountain from 12 to 24. At Meadow Mountain, utilization of physical restraint was down 50%. The use of handcuffs during physical restraints increased at all four youth treatment centers.

The JJMU welcomes the Department's plans to increase the staff to youth ratio at the youth centers. Mid-level management positions have already been added at each center. Additionally, the Department gained approval to provide for 24 new direct care positions.

3. Services For Female Youth

Violence remained low at the Carter Center (DJS operated hardware secure treatment program for girls) and at the Waxter detention center (all-female juvenile detention center in the state). The addition of trauma-informed trainings for supervisory staff at Carter was an important advancement for the program. The JJMU welcomes the Department's plans for the statewide introduction of trauma-informed programming in conjunction with training for all DJS staff.

Girls at Carter (and boys at Victor Cullen) continue to be placed in handcuffs, belly chains and shackles during transportation to and from off-grounds medical appointments, and remain in mechanical restraints during receipt of medical services. Pregnant girls at Carter wear handcuffs during transportation to and from off-grounds medical appointments and during receipt of medical services, except during their final trimester, when no mechanical restraints are used.

Plans to expand vocational opportunities and improve case management services for girls should go forward as recommended by the 2012 Girls' Services Workgroup.

MONITOR'S OBSERVATIONS

The Department's internal investigatory unit, the DJS Office of the Inspector General (DJS-OIG), investigates critical incidents that occur in DJS operated/licensed facilities. Investigations by the DJS-OIG include details of video footage (when available) and summaries of alleged events based on incident reports, witness statements and interviews. The DJS-OIG can also decide not to initiate a full investigation and instead refer an allegation involving staff misbehavior back to facility management for a facility level review.

Currently, the Department does not inform the JJMU when a DJS-OIG investigation or a facility level management review is initiated.

Additionally, although the Department continues to forward copies of completed DJS-OIG investigations to the JJMU, the investigations no longer include findings (i.e. whether it was determined that there was a violation of DJS policy). This is because the DJS-OIG no longer forms conclusions or makes recommendations as part of the DJS-OIG investigatory process.

The Department should ensure that there is a mechanism to inform the JJMU when a DJS-OIG investigation or a facility level management review is initiated in all cases where an investigation or review stems from staff interaction with youth at DJS-operated or DJS-licensed facilities. The Department should also inform the JJMU about the results of such investigations and reviews including whether or not violations of policy and procedure were found to have occurred or were unproven. Such information does not need to include the specifics of any disciplinary actions.

In addition to an investigations unit, the DJS-OIG also includes a Quality Assurance (QA) unit that is responsible for conducting regular audits of DJS facilities. Previously, the JJMU received copies of all audits produced by the QA unit. The JJMU continues to receive copies of QA audits of DJS-licensed programs but no longer receives copies of QA audits of DJS-operated detention facilities. The Department should provide the JJMU with copies of all targeted and comprehensive audits produced by the QA unit, as was the previous practice.

Beginning on July 1, 2013, the Department changed the way in which incidents are reported. Although the changes are in a trial period at time of writing (mid-July, 2013), the JJMU is concerned about some of the changes. For example, the new system distinguishes between "fights" and "assaults" based on the nature of each youth's involvement in the incident. This distinction arguably makes incident reporting at the facility level a more subjective process than before.

The new system also disallows the application of multiple categories to a single incident. For example, an incident where there was a youth on youth physical assault that included a restraint of youth by staff, and resulted in an allegation of abuse stemming from the restraint, would be categorized as a fight or an assault, with the

restraint recorded within the incident report. While the abuse allegation may be reported to Child Protective Services, the Maryland State Police and the DJS-OIG, the incident may not be categorized in the DJS Incident Reporting Database as an allegation of abuse because the incident category is determined by the “precipitating event” rather than the most serious event/allegation within an incident.

The new method of incident reporting also arguably impairs the ability to record whether incidents were associated with an injury. Reporting injury is now based on three levels of severity, the lowest of which includes “no injury”, but the lowest level also includes injury requiring onsite treatment. Therefore, an incident in which a child or staffer sustains an injury that can be treated at a facility-based infirmary and an incident where there were no injuries will be reported within the same category.

JJMU MONITORING RESPONSIBILITIES

In 1999, the Maryland Department of Juvenile Justice (precursor to the Maryland Department of Juvenile Services/DJS) received national media coverage over the treatment of youth in its boot camp facilities. A Task Force investigation concluded that the Department lacked oversight and recommended creation of an external monitoring agency to report to the Governor and members of the General Assembly on conditions in DJS facilities as well as on the safety and treatment of youth in DJS custody. As a result, the Office of the Independent Monitor was established in 2000.

Legislation to codify the Office of the Independent Juvenile Justice Monitor was passed into law in 2002. In 2006, the monitoring unit was moved to the Office of the Attorney General and renamed the Juvenile Justice Monitoring Unit (JJMU).

JJMU – VISITS AND REPORTS IN FISCAL YEAR 2013

During fiscal year 2013, the Juvenile Justice Monitoring Unit (JJMU) staff consisted of 3 fulltime monitors (José Saavedra, Tim Snyder and Eliza Steele) and a director-monitor (Nick Moroney). The Unit conducted or attended 380 facility visits and facility-related meetings and produced 67 facility reports and an annual report covering the 2012 calendar year. JJMU reports are available online at: http://www.oag.state.md.us/JJMU/index.htm

Maryland Department of Juvenile Services
Successful Youth • Strong Leaders • Safer Communities

August 8, 2013

DJS Response to the Juvenile Justice Monitoring Unit (JJMU) 2013 2nd Quarter Report

The Department of Juvenile Services (DJS) appreciates the time and effort that JJMU has taken to draft and submit their 2nd Quarter Report for 2013. We have thoughtfully considered all findings and suggestions and will take corrective action in areas of need.

We appreciate the JJMUs acknowledgement of the Department's success in maintaining a reduction in detention populations at the Baltimore City and Baltimore County detention centers. An integral part of this achievement has been the progress made in reducing the length of time youth spend in detention awaiting court ordered residential placements. As reported, the Department has achieved a reduction of 81% at Cheltenham Youth Center, 71% at Baltimore City Juvenile Justice Center, and 70% at Charles H. Hickey Jr. School for youth who await placement 60 days or more compared to the same time in 2012.

The Department operates fourteen residential facilities (seven detention and seven residential treatment facilities). Incidents of aggression have remained low and reductions have been achieved in twelve of the fourteen sites compared to the 2nd Quarter of 2012. The Department conducts in-depth assessments monthly at sites where incidents have increased. Management and executive staff collaborate to develop intervention strategies. The safety of staff and youth and public safety is our highest priority in establishing an environment conducive to providing rehabilitative services to our youth.

The report sites overcrowding at three detention facilities, Cheltenham Youth Center, Western Maryland Youth Center, and the Lower Eastern Shore Children's Center. On the occasions when the population exceeds the rated capacity, the Department requires that each facility increase staffing to maintain supervision standards to ensure the safety of staff and youth. Youth are occasionally moved to facilities where there are vacant beds. In February 2012, the Department in partnership with the court, law enforcement, and state's attorneys launched the Juvenile Detention Alternative Initiative in Prince George's County to develop practices to address the use of detention and detention alternatives. This work is ongoing. The Cheltenham Detention facility, located in Prince George's County, exceeded the rated capacity three days during this quarter.

The JJMU reports concerns regarding the role of the Office of the Inspector General (OIG). The OIG is the investigative unit for the Department, with reporting responsibility directly to the Secretary. The OIG investigates incidents in accordance with department policy and procedures, and at the request of executive and managerial staff. The OIG is expected to conduct interviews, review evidence and document the factual findings of each case in a report. These reports are shared with the JJMU, the facility superintendent, and the DJS executive team. The OIG is an investigative unit and is not expected to make recommendations for discipline. Staff performance and accountability is the responsibility of the administrative and executive staff. The OIG is also not tasked with investigating allegations of youth abuse. All allegations of abuse or neglect are referred to Child Protective Services for investigation and findings.

Quality Assurance reports at DJS operated facilities contain sensitive information regarding security practices, staffing patterns, as well as measures taken to ensure community safety. The prior practice to which JJMU refers was discontinued over two years ago and did not focus on facility safety and security. The purpose of the change in practice is to ensure that the facilities are operated in a safe manner and to minimize opportunities for escapes to occur. DJS does not make public any information which, if discovered by youth residing in those facilities, compromises community safety or the safety of staff supervising those youth.

Beginning on July 1, 2013, the Department rolled out an upgrade of the incident reporting process and database. Changes were made to more clearly define incident reporting categories, and to more accurately capture data. These changes were necessary to improve management reports that are used to determine behavioral interventions and staff performance issues. The revisions will be reviewed one month following implementation and prior to finalizing the process. The JJMU report cites several findings regarding the database that are not accurate. First, the database continues to capture multiple categories relative to a single incident; secondly, injuries are associated specifically with the event and are categorized in three levels determined by the type of medical care required, incidents not requiring medical care are not included in the lowest level; thirdly, all incidents of abuse or neglect are recorded as a separate incident report. The Department will continue to work cooperatively with the JJMU to provide them with requested data.

Facility Report Responses

Charles H. Hickey, Jr., School

The JJMU report cites an incident of restraint that was reviewed by administrative staff and reported to CPS four days after the incident occurred. The administrative review of this incident did not occur in accordance with the time frame established by procedures; corrective actions have been taken.

Youth at Hickey received a fifty percent increase in scheduled recreation time during the past quarter which led to an increase in sport injuries. Management evaluated foot wear, and the type of activities offered to reduce the occurrence of youth injuries. The

increase in acts of aggression at Hickey have been closely analyzed by management and executive staff. Multi-disciplinary treatment teams have worked collaboratively to develop individualized plans to address the needs of youth involved.

Cheltenham Youth Facility

The JJMU reports a physical restraint in which the youth was unresponsive to staff. The youth was taken to the emergency room where he remained unresponsive until the attending physician ordered an IV and a catheter, at which time the youth spoke up to decline the catheter. The youth was treated for abrasions and returned to the facility. The incident was investigated by the Department's Office of the Inspector General and the Maryland State Police.

Victor Cullen Center

JJMU cites the increase in use of physical and mechanical restraints. Victor Cullen is a hardware secure and open campus facility for boys. When youth become disruptive to the point of requiring physical restraint, handcuffs are applied for movement to a location for de-escalation, for example, youth are removed from school and walked across the campus to a housing unit. These intervention techniques are required to manage the population. Department procedures restrict the use and require administrative review of all incidents of restraint. The Victor Cullen administration and staff work persistently to be responsive to the changing needs of the population.

The Department is currently recruiting for three vacant Behavioral Health positions; two licensed social workers and one licensed substance abuse counselor.

DJS Youth Centers

An increase in incidents occurred at Backbone Mountain and Savage Mountain Youth Centers during this quarter. Management and executive staff have conducted an in-depth analysis of the population, staffing and programming available for the youth at Backbone, Savage and the remaining two Youth Centers. Efforts to reduce acts of aggression include development of individualized treatment plans for youth, additional training for staff, allocation of 24 contractual direct care positions, and establishment of a supervisory structure to improve oversight of facility operations.