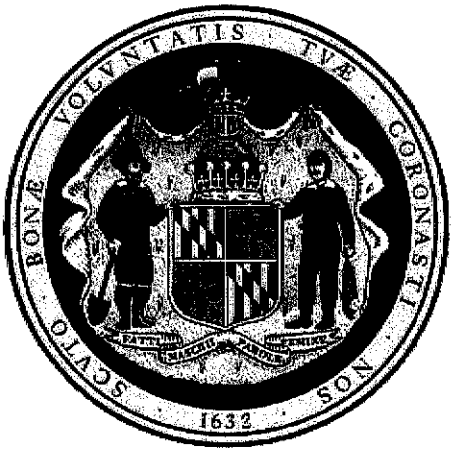

ANNUAL REPORT

JULY 1, 2005 – JUNE 30, 2006

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

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INTRODUCTION

In accordance with the statutory responsibility delineated for the Juvenile Justice Monitoring Unit by Title 6, Subtitle 4 of the State Government Article in the Maryland Code, we respectfully submit this annual report. The following report is the fifth since the original codification of the Office of the Independent Juvenile Justice Monitor in October 2002.

Over the past 5 years, this office has sought to be an instrument of change in the services and safety provided to the youth and communities of this State. To that end, the Juvenile Justice Monitoring Unit maintains its commitment to working with the Department of Juvenile Services and all stakeholders in reporting on conditions impacting the services and safety to youth, staff, and Maryland communities, and to developing of corrective action plans.

This past year has brought several changes to the Office of the Independent Juvenile Justice Monitor (OIJJM), which are more thoroughly explained in the History of the Independent Juvenile Justice Monitor listed below. The OIJJM was originally housed in the Governor's Office for Children Youth and Families, which was allowed to sunset as of July 1, 2005. The OIJJM was subsequently established by Executive Order under the newly formed Governor's Office for Children. In January of 2006, the Maryland General Assembly transferred the OIJJM to the Maryland Office of the Attorney General and the unit was renamed the Juvenile Justice Monitoring Unit (JJMU).

As reflected in the numerous reports generated by the Juvenile Justice Monitors during the past year, Maryland's juvenile justice system continues to face very serious long-standing issues that negatively affect the safety, security and delivery of services to youth. (See Outstanding Issues and Recommendations, pp. 15 of this report). DJS facilities continue to experience a high incidence of serious issues, including life, health, and safety concerns.

Of major concern is the lack of adequate staffing. Though it varies considerably from facility to facility, youth in many instances do not have a reasonable expectation of safety, security and of receiving the necessary and required services. The staffing crisis has persisted for a number of years, and greatly impacts the Department's ability to provide basic needs let alone effective treatment. Some staff persons continue to provide very poor role modeling for the youth. In several instances, staff members have been administratively and criminally charged for abusing youth.

The long length of stay for youth in pre-adjudication status, and in pending placement status in detention facilities has continued to be a significant issue during this past year. The closing of the residential programs at the Charles Hickey School in November of 2005 and the failure to re-open the Victor Cullen Academy have left the State with very few alternatives for youth who require secure placements. This dilemma has resulted in youth spending prolonged periods in a pending placement status awaiting placement in

secure out-of-state facilities or being released back into the community without their needs for effective treatment being met.

The youth on youth violence within the facilities continues to be a major concern. This Unit has repeatedly recommended that all jurisdictions that house State owned and/or operated DJS facilities, engage in efforts to develop written interagency agreements to respond to the problems of child abuse and assaults within those facilities. As of this date, Baltimore City and Anne Arundel County are reportedly still working on their agreements. Baltimore County has had an effective written interagency agreement in place since 2003.

All of the State owned and/or operated detention facilities still have significant physical plant deficiencies that pose life, health, and safety concerns for both youth and staff.

Although repeatedly requested throughout this past year, the Department failed to provide its monthly grievance summaries to this office as required in the Standard Operating Procedures agreement between DJS and OIJJM.

The Department has acknowledged the existence of many of these issues, and has made progress in addressing some of the concerns. The child advocacy community also continues to play a vital role, regarding the issue of addressing the concerns noted above. The Office of the Juvenile Justice Monitoring Unit looks forward to continuing in the work of assisting in the transformation of Maryland's juvenile justice system.

MISSION STATEMENT

To promote the positive transformation of the juvenile justice system to meet the needs of Maryland's youth, families, and communities.

This mission is accomplished by:

- Collaborating with all who are involved with the juvenile justice system;
- Collecting and evaluating all information;
- Reporting findings and recommendations; and
- Monitoring actions taken.

HISTORY OF THE JUVENILE JUSTICE MONITORING UNIT

During the winter of 1999, the former Maryland Department of Juvenile Justice received national media coverage concerning the treatment of youth in their boot camp facilities. A thorough task force investigation of the Department was ordered. One of the outstanding findings of this task force was that there was no oversight of the Department.

Recognizing the need for external review of the Department's residential facilities, the establishment of an Independent Juvenile Justice Monitor was proposed within the Sub cabinet for Children, Youth, and Families. As a result, in February of 2000, the Department of Juvenile Justice and the Sub cabinet for Children, Youth, and Families signed a Memorandum of Agreement (MOA) establishing the Office of the Independent Juvenile Justice Monitor within the Governor's Office for Children, Youth, and Families.

The responsibilities of the Independent Monitor, per the MOA, included reviewing and evaluating the child advocacy grievance process in the Department of Juvenile Justice; the operation of the Department's Inspector General; the treatment of and services to youth; and the physical plant conditions in facilities.

In September of 2000, the Office of the Independent Juvenile Justice Monitor became operational with the hiring of two monitors. However, it became apparent that the Office of the Independent Monitor required additional staffing in order to adequately maintain a level of review consistent with its assigned responsibilities. In late March 2001, three additional monitors were hired through a grant from the Governor's Office of Crime Control and Prevention.

Legislation to codify the Office of the Independent Juvenile Justice Monitor went into law on April 25, 2002 with an effective date of October 1, 2002. As a result of HB 971, funding for the Office was derived from general funds and the statutory duties of the Office were identified, to include the evaluation at each facility of:

- The child advocacy grievance process;
- The Department's monitoring process;
- The treatment of and services to youth;
- The physical conditions of the facility; and
- The adequacy of staffing.

In order to carry out these functions HB 971 provided that the Office shall:

- Review all reports of disciplinary actions, grievances, and dispositions and alterations in the status or placements that result in more security, additional obligations, or less personal freedom.
- Receive copies of the grievances submitted to the Department.

- Perform unannounced site visits and on-site inspections.
- Receive and review all incident reports submitted to the Department from facilities.
- Receive reports of the findings of child protective services investigations of allegations within facilities.
- Be available to attend meetings of the State Advisory Board and facility advisory boards.

Further, HB 971 provided that the Office may:

- Review relevant laws, policies, procedures, and juvenile justice records, including records relating to individual youth.
- On request, conduct interviews with staff, youth, and others.
- Review investigative reports produced by the Department relating to youth in facilities.
- Participate within the context of the local department of social services' multidisciplinary team process, in a child protective services investigation concerning any allegation of abuse or neglect within any assigned facility.

In 2005, the statute authorizing the Governor's Office for Children, Youth and Families and the OIJJM was allowed to sunset. Members of the Maryland legislature and the child advocate community became instrumental in having the OIJJM moved from under the Governor's direct control to a more independent State office. The General Assembly passed House Bill 1342 to transfer the Office of the Independent Juvenile Justice Monitor from the Office of Children, Youths, and Families to the Office of the Attorney General. On January 19, 2006 the Office of the Independent Juvenile Justice Monitor was moved as per HB 1342 to the Office of the Attorney General and renamed the Juvenile Justice Monitoring Unit (JJMU).

HB 1342 has been codified and incorporated into Maryland State Law (See Appendix A).

In January 2006, Ms. Katherine Perez was selected to become the Director of the newly named Juvenile Justice Monitoring Unit (JJMU). In April 2006 Mr. Yusuf Muhammad was selected as the Deputy Director.

All reports produced by the Juvenile Justice Monitoring Unit were made available for view on the Office of the Attorney General's website starting in March 2006.

STAFF

Kathy Perez, Director, directed and coordinated the activities of the office throughout the 2006 fiscal year. Ms. Perez resigned from her position as Director effective August 11, 2006.

Yusuf A Muhammad, Deputy Director, assisted in the coordination of activities in the office. In addition, Mr. Muhammad co-monitored the Cheltenham Youth Facility, J. Deweese Carter Children's Center, Thomas J. S. Waxter Children's Center, and the Guide Catonsville Structured Shelter Care. Mr. Muhammad served 20 ½ years as a Prince George's County, Maryland police officer before retiring in 2004. He then served just over a year as the Chief of Police for the City of Glenarden, Maryland Police Department. As a graduate of the prestigious Police Executive Leadership Program, Mr. Muhammad holds both a Bachelor of Science in Management and a Master of Science in Management from Johns Hopkins University. He is currently enrolled in Stanford University's Advanced Project Management Program.

Philip "Jeff" Merson, Juvenile Justice Monitor, monitors facilities in Central Maryland. He is responsible for the Charles H. Hickey School, the Baltimore City Juvenile Justice Center, the Thomas O'Farrell Youth Center, the Sykesville Shelter Home for females, and the Maryland Youth Residence Center. Mr. Merson served 26 years with the Maryland State Police and retired 1999. He was instrumental in establishing the Child Abuse Sexual Assault Unit in Carroll County, and he spent the last 6 years of his career with the FBI on a Violent Crime Task Force in Baltimore City. Upon retirement, Mr. Merson became the Admissions Coordinator for Bowling Brook Preparatory School, a highly touted private residential treatment facility for aggressive adjudicated young men. Mr. Merson then became an investigator with the Department of Juvenile Justice and served as the Assistant Director of Investigations from 2000 through 2001 before joining the Office of the Independent Juvenile Justice Monitor. Mr. Merson holds a Master's degree in Education from Loyola College.

Kim Bones, Juvenile Justice Monitor, works with facilities in Eastern Maryland. She monitored the Thomas Waxter Children's Center, Cheltenham Youth Center, J. DeWeese Carter Children's Center, Eastern Shore Structured Shelter Care, the Lower Eastern Shore Children's Center, Mount Clare House, and the Catonsville Guide Program in Baltimore City. Ms. Bones resigned from her position as monitor effective July 2006.

Timothy Snyder, Juvenile Justice Monitor, works with facilities in Western Maryland. He is assigned to the Allegany County Girls' Home, the four Youth Centers, the Western Maryland Children's Center, The Alfred Noyes Children's Center and the William Donald Schaefer House in Baltimore City. Mr. Snyder has a Master of Arts degree in Pastoral Counseling with special emphasis in marriage and family counseling from LaSalle University. Mr. Snyder was the Director of the New Dominion School in Maryland for eleven years. New Dominion School is an adventure based residential program for troubled youth. Mr. Snyder also worked in direct care and family services at New Dominion School in Virginia. He served as a consultant to families experiencing

difficulties with their children prior to joining the Office of the Independent Juvenile Justice Monitor.

Sharon Street, has served as Assistant Attorney General for the Juvenile Justice Monitoring Unit since August 2006. Prior to this position, she has served as an Assistant Attorney General in the Office of the Attorney General's Environmental Crimes Unit and Correctional Litigation Division. She also served as a Staff Attorney with the Division of Pretrial Detention and Services. Ms. Street began her legal career as an Associate with the law firm Brown, Goldstein & Levy. Ms. Street graduated from the University of Maryland School of Law. She completed her undergraduate studies at the University of Delaware.

Melanie Sokolovich, has served as Administrative Assistant to the Juvenile Justice Monitoring Unit since April 2006. She provides ongoing support for the activities of the Unit. Prior to this position, Mrs. Sokolovich was a legal secretary in the Criminal Appeals Division in the Office of the Attorney General and the Consumer Protection Division. She has been part of the Office of the Attorney General staff since 1998.

ASSIGNED DJS FACILITIES

FACILITY	LOCATION	MONITOR
Allegany Girls Group Home	Allegany County	Tim Snyder
Green Ridge Youth Center	Allegany County	Tim Snyder
Thomas J. S. Waxter Children's Center	Anne Arundel County	Kim Bones & Yusuf Muhammad
Baltimore Juvenile Justice Center	Baltimore City	Jeff Merson
Ferndale Group Home	Baltimore City	Closed
Maryland Youth Residence Center	Baltimore City	Jeff Merson
Mount Clare House	Baltimore City	Kim Bones
William Donald Schaefer House	Baltimore City	Tim Snyder & Yusuf Muhammad
Guide Northeast Shelter Home	Baltimore County	Kim Bones
Charles H. Hickey, Jr. School	Baltimore County	Jeff Merson
Thomas O'Farrell Youth Center	Carroll County	Jeff Merson
Sykesville Group Shelter Home	Carroll County	Jeff Merson
Eastern Shore Structured Shelter Care	Dorchester County	Closed
Victor Cullen Academy	Frederick County	Closed
Backbone Mountain Youth Center	Garrett County	Tim Snyder
Meadow Mountain Youth Center	Garrett County	Tim Snyder

Savage Mountain Youth Center	Garrett County	Tim Snyder
J. DeWeese Carter Children's Center	Kent County	Kim Bones & Yusuf Muhammad
Alfred D. Noyes Children's Center	Montgomery County	Tim Snyder
Cheltenham Youth Facility	Prince George's County	Kim Bones & Yusuf Muhammad
Hagerstown Holdover Program	Washington County	Closed
Western Md. Children's Center	Washington County	Tim Snyder
Lower Eastern Shore Children's Center	Wicomico County	Kim Bones

OFFICE ACTIVITIES FOR FISCAL 2005

VISITATION

Juvenile Justice Monitors are assigned to specific facilities as reflected above. The Juvenile Justice Monitoring Unit was designed so that monitors would be deployed on a regional basis in order to maximize the level of visitation. Additionally, the monitors make team visits as needed. Visits by monitors may occur at any time, including evenings and/or weekends when there may be higher incidence of problems. Most visits are unannounced. Also, monitors make more frequent visits to the larger, physically secure facilities, due to the higher incidence of issues within these programs. During FY 2006, the Juvenile Justice Monitors made 339 visits to 19 facilities. (see Appendix B).

During visits, the monitors review facility records including cottage logs, grievance reports, incident reports, suicide watch forms, medical data, and staffing assignments. Additionally, conducting youth and staff interviews is a crucial aspect of the monitoring process. Finally, the monitors make inspections of the facilities to determine the status of the physical plant.

The monitors attend and participate in facility Advisory Board meetings. The Advisory Boards meet on at least a quarterly basis, and consist of members of the community and local governing bodies who are charged with making recommendations to State Advisory Board and the Secretary of DJS to improve the conditions within these facilities.

REPORTING

Written reports are developed and submitted and are based on the monitors' visitations and observations made at the facilities. Timely Reports have been issued to the Children's Cabinet, the Secretary of the Department of Juvenile Services, the Executive Director of the Governor's Office for Children, the Attorney General, the Speaker of the House, and the President of the Senate on a quarterly basis. Special Timely Reports detailing significant events are occasionally issued on a more frequent basis, as circumstances dictate. Both types of reports contain the monitor's findings and corrective action recommendations.

The Juvenile Justice Monitoring Unit then meets with DJS officials to review the report and recommendations, making any changes that are deemed appropriate by the JJMU. The Department of Juvenile Services is charged with completing a corrective action plan to address and remedy the issues cited.

In addition to the Timely Reports, the Juvenile Justice Monitoring Unit issues Quarterly Reports, a summarized version of the findings and recommendations contained in the Timely Reports. The Quarterly Reports also contain the Department of Juvenile Services' responses to the Juvenile Justice Monitoring Unit's findings and recommendations.

On or before November 30th the Juvenile Justice Monitoring Unit issues an Annual Report. The Timely Reports, Quarterly Reports and the Annual Report may be accessed on the Internet at: www.oag.state.md.us.

When the Juvenile Justice Monitoring Unit was housed in the Governor's Office for Children Youth and Families, a Standard Operating Procedure (SOP) was developed.

(See Appendix C) The SOP was ratified in November of 2003 between OCYF and DJS.

REVIEW OF DJS INCIDENT AND INVESTIGATIVE REPORTS

The Department of Juvenile Services maintains an incident reporting database, which the Juvenile Justice Monitoring Unit may access via the Internet. Monitors regularly review this database as well as other reports and information resulting from their visits. In addition, DJS provides the Juvenile Justice Monitoring Unit with copies of completed investigative reports. The information gathered from the review of the incident reporting process and the investigative reports allows monitors to determine whether accurate information is being collected by the Department regarding facility operations, assists in the collaboration with the Department's internal monitoring and investigation division (Office of Professional Responsibility and Accountability – OPRA), and helps identify potential trends within facilities.

DATABASE (ASSIST) REVIEW

The Department of Juvenile Services maintains a comprehensive database (ASSIST) that details the arrest, placement, programming, social history, and other pertinent information for every client who has been involved with the DJS system. Monitors from the JJMU have access to the ASSIST database via the internet and often utilize that information to follow-up on investigations or collaborate with DJS officials to determine if a particular youth's needs are being met.

GRIEVANCE REVIEW

Monitors discuss with youth the youth's knowledge of and satisfaction with the Department of Juvenile Services' grievance process. The Department of Juvenile Services assigns Child Advocates to facilities to review and process youth grievances. If a youth has not forwarded a grievance to the assigned Child Advocate, the monitor will normally encourage him or her to do so, or the monitor might make the referral on behalf

of the youth. The monitors also engage in dialogue with the Child Advocates regarding activities and concerns within the facilities.

LEGISLATIVE AND POLICY ADVOCACY

The Juvenile Justice Monitoring Unit, as part of the Governor's Office for Children, Youth, and Families and subsequently with the Governor's Office for Children, and the Office of the Attorney General has had the opportunity to review and offer comment on proposed legislation impacting youth.

CHILD ABUSE AND NEGLECT

Abuse of youth within residential settings has been a particular concern of the Juvenile Justice Monitoring Unit. The JJMU has identified numerous issues associated with the system of reporting, investigating, and disposition of allegations involving the abuse and neglect of youth within residential settings. Not all cases of suspected child abuse are being reported to the proper authorities and there have been some coordination problems between the Department of Juvenile Services, local Departments of Social Services and the appropriate law enforcement entity regarding their investigatory initiatives. Further, one agency may not know of the other's disposition of a case.

Maryland Code/State Government/Title 6/Subtitle 4 permits the Juvenile Justice Monitoring Unit to receive notice from local Department of Social Services when an allegation of abuse and neglect is reported within one of the facilities assigned to the JJMU. Further, the JJMU may participate in a multidisciplinary team process with the child protective services investigation.

In February 2004 the Maryland Attorney General issued an opinion in response to an inquiry by the Governor's Office for Children, Youth, and Families concerning, what was then the Office of the Independent Juvenile Monitor, the monitor's function with regard to the reporting of child abuse and neglect. The Attorney General concluded that the monitor may, and should, include findings and recommendations regarding public agency performance in response to allegations of child abuse and neglect at DJS facilities, while complying with appropriate law governing confidentiality. Further, the opinion held that as long as the monitor's report is in compliance with confidentiality requirements that the report may be subject to public inspection pursuant to a Maryland Public Information Act request.

The Juvenile Justice Monitors have been instrumental in bringing together personnel from the local Department of Social Services, State Police, State's Attorney's Office, and Department of Juvenile Services to develop a draft protocol for the handling of allegations concerning abuse and neglect in a number of jurisdictions. One such agreement, the Baltimore County Interagency Agreement on the Investigation of Child Abuse and Neglect at the Charles H. Hickey School, was signed by all concerned parties and enacted on April 22, 2004 and re-written to accommodate the State's takeover on July 1, 2004 (See Appendix E).

INTERAGENCY RELATIONS

The Juvenile Justice Monitoring Unit established productive working relationships with other youth-serving agencies and organizations. These agencies and organizations include:

- Detention Response Unit of the Baltimore Public Defender's Office
- Maryland Disability Law Center
- Suicide Prevention Network
- American Bar Association
- Annie E. Casey Foundation
- National Juvenile Detention Association
- American Correctional Association
- National Center on Institutions and Alternatives
- State Juvenile Justice Advisory Board
- State Juvenile Justice Advisory Councils
- Maryland State Police
- State's Attorney's Offices
- Maryland Association of Resources for Families and Youth
- Maryland Juvenile Justice Coalition
- Local Management Boards
- Local Departments of Social Services

ACCOMPLISHMENTS

- Throughout this past year of transitions and significant loss of staff, the remaining three monitors from the Juvenile Justice Monitoring Unit, along with support from the Governor's Office for Children, maintained an ambitious facility visitation schedule, maintaining the issuance of Timely Reports, Quarterly Reports, special Reports, and an Annual Report as required. These activities continued and expanded in January with the appointment of a new Director and Deputy Director to the Juvenile Justice Monitoring Unit, and with the support and assistance of the Office of the Attorney General.

- Staff from the Unit also attended and participated in statewide boards, workgroups and committees. A summary includes:
  - Juvenile Justice Advisory Board
  - Facility Advisory Board meetings
  - Montgomery County Commission on Juvenile Justice
  - Youth Center Supervisor meetings
  - Out of Home Legislative Workgroup
  - Interagency Institutional Abuse Workgroup
  - DJS Due Process Development Workgroup
  - Citizen Advisory Committee
  - Maryland Female Taskforce
  - Detention Reform Committee

- Task Force to Study the Mentoring and Monitoring of Children in the Custody of or Under the Supervision of DJS
- Restraint and Seclusion Task Force
- Children's Justice Act Committee
- Child Abuse Multidisciplinary Teams

- Initiated and continued to be involved in efforts to develop and/or update Institutional Child Abuse Response Protocol Agreements between local Child Protective Services, the Maryland State Police, the Department of Juvenile Services and juvenile facilities.

- The Juvenile Justice Monitoring Unit provided ten (10) six-hour training modules on Child Abuse and Neglect Recognition and Reporting and ten (10) two-hour training modules on Juvenile Rights for approximately 300 new employees of the Department of Juvenile Services. The Unit also provided five (5) two-hour training modules for refresher training on Child Abuse and Neglect Recognition at local facilities for approximately 50 employees of the Department of Juvenile Services. These entrance level and in-service training courses are certified through the Maryland Police and Corrections Training Commission.

- Issued several special reports outlining findings and recommendations in response to significant incidents within Department of Juvenile Services' facilities.

- Recommended numerous physical plant enhancements, which were completed.

- Posted the unit's reports on the MOAG website for public review.

FINDINGS AND RECOMMENDATIONS AND DEPARTMENT OF JUVENILE SERVICES ACTIONS

The Juvenile Justice Monitoring Unit (JJMU) submitted quarterly Timely Reports and Quarterly Reports for each facility under its purview throughout the fiscal year. The Department of Juvenile Services (DJS), in accordance with established protocol, submitted Corrective Action Plans with regard to the findings and recommendations contained in those Timely and Quarterly Reports. The JJMU's Quarterly Report (see appendix F) covering April – June 2006 provides a current summary of issues by facility and the Department of Juvenile Services' reported actions to those issues.

The JJMU also submitted several Special Timely Reports during the fiscal year:

On August 3, 2005, the JJMU conducted a visit to the Baltimore City Juvenile Justice Center facility in response to a report from the Public Defender's Office regarding a serious youth-on-youth assault that resulted in one youth being hospitalized with a fractured eye socket and injury to his trachea/neck area.

On August 5, 2005 the JJMU issued a Special Timely Report documenting serious threats to life, health, and safety at the Baltimore City Juvenile Justice Center. Previous visits and a visit on August 3 also revealed that youth were still accessing the second tier unaccompanied by staff, even after a recent attempted suicide by hanging from the second floor tier on July 26, 2005. There were also concerns surrounding the seclusion of a youth beyond 24 hours and a restraint procedure that was incorrectly used on a youth. The restraint procedure resulted in an injury to the youth and allegations of child abuse on the staff member applying the procedure. The Special Timely Report identified concerns of inadequate staffing, improper housing procedures, improper restraining techniques, improper use of seclusion, failure to provide effective suicide prevention measures, and failure to notify the Department of Social Services (DSS) of suspected Child Abuse/Neglect. In accordance with established protocol, DJS subsequently submitted a Corrective Action Plan with regard to the findings and recommendations contained in the Special Timely Report.

On February 1, 2006, during an unannounced visit to the Thomas J. S. Waxter Children's Center, monitors from the JJMU witnessed a suspected child abuse incident where a staff member was seen punching a youth. The Unit notified the DJS Office of Professional Responsibility and Accountability (OPRA), the local DSS, and the Maryland State Police (MSP). These agencies worked cooperatively and shared the information gathered. On March 28, 2006, the JJMU issued a Special Timely Report documenting the suspected child abuse incident. In accordance with established protocol, DJS submitted a Corrective Action Plan with regard to the findings and recommendations contained in the Special Timely Report.

On March 4, 2006 monitors were conducting an unannounced visit at the Lower Eastern Shore Children's Center when they witnessed youth sleeping on the floors in the bathrooms due to overcrowded conditions and staffing shortages. The Unit notified DJS/OPRA and the local DSS to conduct investigations. On March 28, 2006, the JJMU issued a Special Timely Report documenting the staffing shortages and the overcrowded conditions at the facility. In accordance with established protocol, DJS submitted a Corrective Action Plan with regard to the findings and recommendations contained in the Special Timely Report.

On May 24 and May 26, a JJMU monitor uncovered concerns relating to falsified training at the Cheltenham Youth Facility (CYF). The JJMU notified DJS/OPRA and the DJS Office of Professional Development and Training (OPDT) to report the concerns. A collaborative and comprehensive investigation was completed by JJMU and DJS. On June 28, 2006, the JJMU issued a Special Timely Report concerning the training and documentation issues at the facility. In accordance with established protocol, DJS submitted a Corrective Action Plan with regard to the findings and recommendations contained in the Special Timely Report.

OUTSTANDING ISSUES AND RECOMMENDATIONS

DETENTION OVERCROWDING AND INADEQUATE STAFFING

- Overpopulation often results from excessive admissions and prolonged lengths of stay, due largely to youth who are pending permanent placement because of their mental health or violent behavior.
- Populations exceed budgeted capacity and architectural design and create inadequate staffing ratios.
- Staffing is inadequate in facilities to provide a reasonable expectation of safety for youth.
- Life, health and safety issues persist in many facilities, imperiling both youth and staff.
- Youth are often idle, especially during weekends and evenings, when staffing is minimal.
- DJS should continue the use of its intake risk assessment tool to screen for detention admission.
- Shelter placements and other community alternatives to detention have been initiated, but those strategies must be aggressively pursued.
- Youth are sometimes placed in facilities which lack the full complement of services and/or security needed to provide adequate treatment and safety.
- Some youth are placed in the DJS Youth Centers non-fenced open programs, which exceed the stated criteria for enrollment. These improperly placed youth can pose serious threats to other youth, staff and/or the community.

CHILD ABUSE

While progress in the identification, reporting, investigation and disposition of residential child abuse and neglect allegations has been made, continued focus on this matter must occur. The Baltimore County Interagency Agreement addressing roles and responsibilities in the reporting and investigation of allegations of abuse and neglect at the Charles H. Hickey School has served as a model for other jurisdictions (See Appendix E). However, the rate of abuse and neglect continues at unacceptable levels in DJS facilities. A coordinated and comprehensive approach by all responsible agencies is required in order to appropriately address this issue.

CONTINUED ASSAULTS

High incidents of youth-on-youth and youth-on-staff assaults continue in some of the facilities. DJS lacks quality control procedures in many facilities and, although some hand-held video monitoring of specific incidents has been implemented, this Office continues to recommend the installation of stationary/panning video monitoring equipment in the facilities along with more managerial reviews of operations.

USE OF SECLUSION

Seclusion has often been used inappropriately and has been poorly processed. Detention facilities on the Eastern Shore and in Western Maryland use seclusion rather sparingly,

while the Baltimore City Justice Center continues to use seclusion on a more regular basis. The Charles Hickey School also uses seclusion inappropriately, setting specific time constraints regardless of the youth's behavior or offense.

SUICIDE POLICY

The suicide prevention policy and procedure has not been fully and consistently implemented. DJS has violated its own policy and procedure by means of its inability to adequately screen, refer and supervise suicidal youth. Also, many youth with severe mental health issues remain in DJS facilities, which are not equipped to appropriately serve this population. Facility practice must comply with adopted policy and procedure in order to ensure the safety of youth. Alternative resources are required to appropriately address this problem.

STAFF HIRING AND TRAINING

Training for both line and supervisory staff has increased. The lack of strong positive role models among staff, a small qualified recruitment pool and a poor quality of life for staff at the facilities due to overcrowding, staff shortages, low pay and/or forced overtime, all contribute to the problems within DJS facilities. The National Juvenile Detention Association has conducted a staff training needs assessment at BCJJC, Cheltenham, Hickey and Waxter over the past two years but there has been no final findings and recommendations published based on those assessments.

DJS's process of hiring and training of new staff is too protracted. After requesting to fill a vacated position, it often takes a facility up to a year or more to be given permission from DJS Headquarters to begin the hiring process. Subsequent to approval to hire, it often takes 4 to 6 months from the date of interview until a new staff recruit is on board.

It is recommended that DJS develop much more effective recruiting strategies and the entire recruiting, screening, and hiring process should be streamlined to facilitate a timely provision of staffing in DJS facilities. The recruiting process should include developing ongoing relationships with colleges and universities throughout the tri-state area in an effort to recruit qualified candidates. Several individual facilities have been proactive by developing these relationships already; however, the effort should be done department-wide.

OVER-RELIANCE ON STATE-OPERATED RESIDENTIAL CARE PROGRAMS

Localities have little or no responsibility to provide services to youth involved in the juvenile justice system. For youth requiring services beyond what may be available by non-profit or other small organizations within a jurisdiction, the court system must rely upon committing a youth to the custody of the Department of Juvenile Services, even if the court wishes to have the youth placed in a group home, which should be an extension of the local community and affiliated social and educational services. Youth only requiring more structured community programming and not secure placement are then usually placed in a detention facility, such as Cheltenham and Hickey pending DJS processing and, it is hoped, eventually placement in a group home if space is found. This results in youth being unnecessarily detained, minimally delinquent youth being exposed to severely delinquent youth, overcrowding in detention facilities, prolonged time in

finding placements, inappropriate placements occurring due to the system relying upon first available vacant bed regardless of the youth's needs, and youth not being placed closer to family and other support systems.

The system must be redesigned to create more local, community programs and viable options outside of state care for the juvenile court. A number of states have created such incentives for local jurisdictions, thereby, maximizing community programming and services.

ANTIQUATED AND POORLY DESIGNED FACILITIES

Improvements have been scheduled and are underway in some of the facilities; however, many facilities are antiquated and functionally obsolete. The Maryland Youth Residential Center, William Donald Schaeffer House, Thomas O'Farrell Youth Center, Charles H. Hickey School, Cheltenham Youth Facility, Baltimore City Juvenile Justice Center, Lower Eastern Shore Children's Center, and Western Maryland Children's Center, all have significant physical plant deficiencies that pose safety concerns for both youth and staff. These issues not only impact the ability to deliver services, but create public safety concerns due to the lack of security. There have been a number of escapes this year from DJS detention facilities to include Cheltenham, Hickey, Noyes, Waxter, and the Baltimore Juvenile Justice Center. The capital improvement plan for these facilities should take into account the need to renovate and consolidate the footprint of structures to improve operations and security/supervision.

STANDARDS

The Department of Juvenile Services has embraced the Council of Juvenile Correctional Administrators' (CJCA) Performance Based Standards (PBS) for Youth Correction and Detention Facilities as a self-improvement and accountability system to improve conditions of confinement at juvenile facilities. PBS sets national standards for the safety, education, health/mental health services, security, justice and order within facilities. In addition, the PBS gives agencies the tools to collect data, analyze the results to design improvements, implement change, and then measure effectiveness with subsequent data collections. However, a comprehensive set of standards governing the Department of Juvenile Services, both for secure and non-secure facilities, is still lacking. Standards still do not exist for Department of Juvenile Services' operated facilities such as short-term shelters, group homes, and commitment care programs. Further, DJS operated facilities are exempt from complying with the Code of Maryland Regulations (COMAR) standards to which privately operated programs must adhere.

FAMILY ADVOCACY CENTER

On September 5, 2005 the Baltimore City Juvenile Justice Center opened its Family Resource Center (FRC) in cooperation with the Family League of Baltimore and DJS. The FRC has been active in providing assistance to the families and friends of youth who are being detained at the facility.

APPENDIX A
Executive Order
01.01.2005.35

EXECUTIVE ORDER
01.01.2005.35

Office of the Independent Juvenile Services Monitor

WHEREAS, The Office of the Independent Juvenile Justice Monitor was established through a memorandum of agreement between the then Department of Juvenile Justice and the Governor's Office of Children, Youth, and Families in 2000. It was codified in Article 49D of the Annotated Code of Maryland by Chapter 255 of 2002 and placed within the Office of Children, Youth and Families;

WHEREAS, Article 49D will sunset on June 30, 2005;

WHEREAS, The General Assembly passed House Bill 1342 - Juvenile Justice Monitoring - Transfer to Office of the Attorney General to transfer all duties of the Office of the Independent Juvenile Justice Monitor from the Office of Children, Youth, and Families to the Office of the Attorney General;

WHEREAS, Under House Bill 1342, the Attorney General would have been placed in the position of having employees of one unit within the office testifying against a department represented by another employee within the office, thereby presenting conflicts which could have jeopardized the integrity of the State's effort to ensure that our juvenile facilities are operated in compliance with federal and State law; accordingly, the Governor vetoed House Bill 1342; and

WHEREAS, It is imperative that we ensure our juveniles are housed and treated in ways which will both protect public safety and present the best opportunities for rehabilitation and reduced recidivism. Therefore, it is appropriate to re-establish the Office of Independent Juvenile Justice Monitor and locate the Office within the Governor's Office for Children.

NOW, THEREFORE, I, ROBERT L. EHRLICH, JR., GOVERNOR OF THE STATE OF MARYLAND, BY VIRTUE OF THE AUTHORITY VESTED IN ME BY THE CONSTITUTION AND LAWS OF MARYLAND, HEREBY PROCLAIM THE FOLLOWING EXECUTIVE ORDER, EFFECTIVE IMMEDIATELY:

A. Definitions. The following words have the meanings indicated.
   1. "Children's Cabinet" means the Children's Cabinet established by Executive Order 01.01.2005.34.
   2. "Director" means the Director of the Office of the Independent Juvenile Services Monitor.

3. "Disciplinary action" means any punitive action against a child that results in more security, additional obligations, or less personal freedom.
4. "Department" means the Department of Juvenile Services.
5. "Executive Director" means the Executive Director of the Governor's Office for Children.
6. "Facility" means:
    a. A residential facility operated by the Department; and
    b. A residential facility owned by the Department but privately operated.
7. "Grievance" means a complaint made by a child or on behalf of a child due to a circumstance or action considered to be unjust. "Grievance" does not include an employee grievance, disciplinary appeal, or complaint.
8. "Independent Juvenile Services Monitor" means the Director of the Office of the Independent Juvenile Services Monitor and any individual designated by the Director to determine whether the needs of children under the jurisdiction of the Department are being met in compliance with State law, that their rights are being upheld, and that they are not being abused.
9. "Office" means the Office of the Independent Juvenile Services Monitor.
10. "Secretary" means the Secretary of Juvenile Services.

B. Established. There is an Office of the Independent Juvenile Services Monitor as an independent unit in the Governor's Office for Children

C. Organization.
1. The Office shall include a full-time Director and staff as provided in the State budget.
2. All salaries for the Director and independent juvenile justice monitors and expenses for rent, equipment, supplies, and general operating expenses necessary for the work of the Office shall be as provided in the State budget.
3. In cooperation with the Secretary of Budget and Management, the Director shall set minimum salaries, qualifications, and standards of training and experience for positions with the Office.

D. Duties and Responsibilities.
1. The Office shall:
    a. Evaluate at each facility:
        i. The child advocacy grievance process;
        ii. The Department's monitoring process;
        iii. The treatment of and services to youth;
        iv. The physical conditions of the facility; and

v. The adequacy of staffing.

b. Review all reports of disciplinary actions, grievances, and grievance dispositions received from each facility and alterations in the status or placement of a child that result in more security, additional obligations, or less personal freedom;

c. Receive copies of the grievances submitted to the Department;

d. Perform unannounced site visits and on-site inspections of facilities;

e. Receive and review all incident reports submitted to the Department from facilities;

f. Receive reports of the findings of child protective services investigations of allegations of abuse or neglect of a child in a facility; and

g. Be available to attend meetings of the advisory boards established under Article 83C, § 2-119 of the Code.

2. The Office may:

a. Review relevant laws, policies, procedures, and juvenile justice records, including records relating to individual youth;

b. On request, conduct interviews with staff, youth, and others;

c. Review investigative reports produced by the Department relating to youth in facilities; and

d. Participate, within the context of the local department of social services' multidisciplinary team process, in a child protective services investigation conducted under Title 5, Subtitle 7 of the Family Law Article concerning any allegation of abuse or neglect within any assigned facility.

3. Reports.

1. The Office shall report in a timely manner to the Children's Cabinet, the Executive Director, the Secretary, and in accordance with § 2-1246 of the State Government Article, the Speaker of the House of Delegates and the President of the Senate:

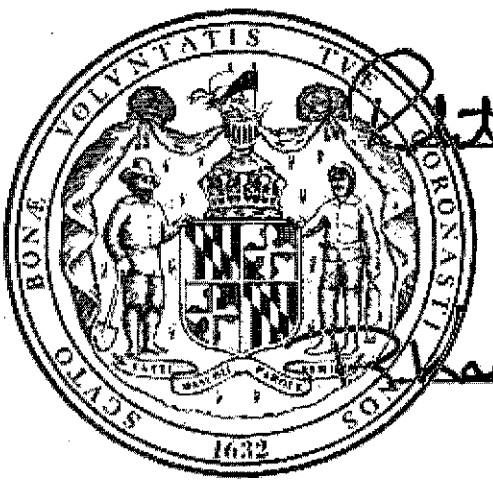
a. Knowledge of any problem regarding the care, supervision, and treatment of children in facilities;

b. Findings, actions, and recommendations, related to the investigations of disciplinary actions, grievances, incident reports, and alleged cases of child abuse and neglect; and

c. All other findings and actions related to the monitoring required under this Executive Order.

2. The Office shall report quarterly to the Executive Director, the Children's Cabinet, and the Secretary.
3. A copy of the report shall be provided to the State Advisory Board for Juvenile Services and, in accordance with § 2-1246 of the State Government Article, the General Assembly.
4. The report shall include:
   . All activities of the Office;
   a. Actions taken by the Department resulting from the findings and recommendations of the Independent Juvenile Services Monitor, including the Department's response; and
   b. A summary of any violations of the standards and regulations of the Department that remain unabated for 30 days or more during the reporting period.
5. On or before November 30 of each year, the Office shall report to the Executive Director.

GIVEN Under My Hand and the Great Seal of the State of Maryland, in the City of Annapolis, this 9th Day of June, 2005.



Robert L. Ehrlich, Jr.
Governor

Attest:

R. Karl Aumann
Secretary of State

APPENDIX B
Visitation Chart

2005-2006 VISITATION BY
THE JUVENILE JUSTICE MONITORING UNIT

FACILITY	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TTL
ALLEGANY GIRLS HOME	1	2	1	1	2	1	1	1	2	0	2	2	**16**
BALT. CITY JUVENILE JUSTICE CENTER	3	3	1	1	2	2	1	1	2	1	4	3	**24**
CARTER	1	1	1	1	2	2	1	1	1	2	1	1	**15**
CATONSVILLE SHELTER	1	1	0	1	1	1	1	1	0	1	1	1	**10**
CHELTENHAM	3	2	2	1	3	2	1	2	2	3	4	3	**28**
HICKEY	2	2	1	1	1	2	2	1	2	2	2	2	**20**
LOWER EASTERN SHORE CHILDREN'S CENTER	1	1	1	1	1	1	1	1	1	1	1	1	**12**
MD. YOUTH RESIDENCE CENTER	1	1	1	1	1	2	1	1	2	1	2	2	**16**
MOUNT CLARE HOUSE	0	1	0	1	1	1	1	0	1	1	1	1	**9**
NOYES	3	5	2	2	3	2	2	2	2	3	2	3	**31**
THOMASO'FARRELL YOUTH CENTER	1	1	1	1	1	2	1	1	2	1	2	1	**15**
WM. DONALD SHAEFER HOUSE	1	1	1	1	1	1	1	1	1	2	0	2	**13**
SYKESVILLE SHELTER	1	1	1	1	1	2	1	1	1	1	1	1	**13**
YOUTH CENTERS													
Green Ridge	1	1	2	1	1	1	1	1	1	2	2	1	**15**
Savage Mountain	1	2	1	1	1	1	1	1	1	1	2	2	**15**
Meadow Mountain	1	1	1	1	1	1	1	1	1	1	2	1	**13**
Backbone Mountain	1	1	1	1	1	1	1	1	1	0	2	3	**14**
THOMAS WAXTER	3	1	5	2	4	5	1	3	0	1	3	2	**30**
W. MD. CHLDRNS CNTR	4	4	4	2	2	2	1	3	1	2	3	2	**30**
TOTALS	**30**	**32**	**27**	**22**	**30**	**32**	**21**	**24**	**24**	**26**	**38**	**33**	**339**

APPENDIX C
Standard Operating Procedure

GOVERNOR'S OFFICE FOR CHILDREN, YOUTH, AND FAMILIES
AND
DEPARTMENT OF JUVENILE SERVICES
STANDARD OPERATING PROCEDURES
FOR THE
INDEPENDENT JUVENILE JUSTICE MONITOR

1.0 Background:

In February 2000, the Maryland Subcabinet for Children, Youth, and Families and the Maryland Department of Juvenile Services (DJS) signed a Memorandum of Agreement (MOA) establishing an Independent Monitor for the Department of Juvenile Justice. A revised Memorandum of Agreement took effect on November 1, 2001. Effective October 1, 2002, the Office of the Independent Monitor was codified under the terms of HB 971, Chapter 255, Laws of Maryland 2002. The Independent Monitor evaluates at each facility the Child Advocacy Grievance process, the DJS monitoring process, the treatment of and services provided to youth at each facility, the physical condition of each facility, and the adequacy of staffing.

2.0 Purpose:

This document outlines the Standard Operating Procedures (SOP) for implementation of the provisions of Chapter 255 and the Independent Monitor MOA by DJS and OCYF. The SOP includes the criteria and standards used in monitoring facilities, the monitoring process itself, the sharing of information between DJS and the Independent Monitor, and the methods of documentation and reporting to the Secretary of DJS and the Subcabinet.

3.0 Definitions:

3.1 "Child Advocate" means an individual who works on behalf of youth under the DJS jurisdiction to ensure youth needs are met and their rights upheld throughout DJS operations.

3.2 "Corrective Action Plan" means a plan developed by DJS and a DJS facility to address findings and recommendations of the Independent Monitor related to that facility.

3.3 "Grievance" means a complaint by or on behalf of a youth concerning a circumstance or action alleged to be unjust. "Grievance" does not include an employee grievance, disciplinary appeal, or complaint.

3.4 "Independent Monitor" means the Independent Monitor for Juvenile Justice or a member of the staff of the Independent Monitor for Juvenile Justice.

3.5 "Monitoring" means the process of assessing performance in accordance with the provisions of Section 4.0.

3.6 "Facility" means a residential facility owned or operated by DJS. A residential facility is a program that provides residential services to youth on a 24-hour basis.

3.7 "Youth" means an individual who is under the jurisdiction of DJS and placed in a facility.

4.0 Monitoring Standards:

4.1 Existing Standards

The Independent Monitor shall monitor using the following standards:

4.1.1 Code of Maryland Regulations (COMAR)

• Title 01 Executive Department, Subtitle 04 Office for Children, Youth, and Families, Chapter 04 Residential Child Care Programs.

• Title 07 Department of Human Resources, Subtitle 02 Social Services Administration, Chapter 07 Protective Services for Neglected and Abused Children.

• Title 16 Department of Juvenile Services.

4.1.2 DJS Secretary Directives and DJS Protocol, Procedure and Guidelines

DJS Secretary's Directives, protocols, procedures, and guidelines governing the care, custody, treatment and supervision of youth at facilities monitored by the Independent Monitor. DJS will provide the Independent Monitor with copies of directives protocols, procedures, and guidelines for inclusion among the Independent Monitor's compliance standards.

4.1.3 DJS Standards for Juvenile Detention Facilities

This volume describes in detail the requirements for operating a detention facility. Though not all facilities that the Independent Monitor reviews are used for detention, many of the standards may apply to other types of residential facilities.

4.1.4 DJS Standards of Conduct and Disciplinary Process

This volume contains rules for DJS employee conduct, attendance and leave, disciplinary sanctions, appeals and grievances, and information about the Investigations and Child Advocacy Unit (ICAU), including: Standards of Conduct and Performance; Attendance Requirements; Disciplinary Sanctions; Implementation of Corrective and Disciplinary Sanctions; Appeals and Grievances; Investigation and Child Advocacy Unit.

4.1.5 Contracts between DJS and private entities

Upon request, DJS shall provide the Independent Monitor with access to or a copy of a contract for the operation of a facility.

4.1.6 Court Orders

Upon request, DJS shall provide the Independent Monitor with copies of relevant court orders. The Independent Monitor shall review such orders when monitoring

4.2 Identification of relevant standards

DJS will provide the Independent Monitor with citations to all statutes and regulations, and copies of all relevant policies, procedures, court orders and contract provisions that it has determined are relevant to the monitoring process. DJS and the Independent Monitor will work collaboratively in identifying revisions and additions to these standards.

4.3. Identification of Other Monitoring Concerns

As part of monitoring whether facilities are in compliance with the standards

identified in Sections 4.1 and 4.2, the Independent Monitor may also address other conditions and situations that jeopardize the effectiveness of the DJS grievance and monitoring processes, the treatment of and services to youth at each facility, the physical condition of each facility, and the adequacy of staffing for which:

A. no current standards applicable to DJS can be identified; or

B. the Independent Monitor believes that current standards afford inadequate protection of the health, life, safety and humane treatment of youth in a DJS facility. If the Independent Monitor determines that current standards afford inadequate protection of the health, life, safety and humane treatment of youth in a DJS facility, the Independent Monitor shall identify the deficiency in current standards related to the concern and provide recommendations pursuant to Section 7.0. The Independent Monitor may report associated findings and recommendations in accordance with the reporting requirements in Section 6.1.

5.0 Monitoring Process:

The Independent Monitor has a formalized monitoring and reporting process to ensure that on-site visits to facilities result in identifying and reporting to the Secretary of DJS in a timely manner, any material deficiencies in treatment and services or immediate threats to the health, life, safety and humane treatment of youth under DJS care, custody or supervision.

5.1 The Independent Monitor may conduct unannounced and unscheduled visits to facilities.

5.2 The Independent Monitor shall develop and use monitoring tools for collecting and documenting information obtained during the on-site monitoring visit, including interviews, review of records, and observation.

5.2.1 The Special Secretary shall approve any monitoring tools used by the Independent Monitor.

5.2.2 The Secretary of DJS shall have the opportunity to provide input regarding the monitoring tools prior to approval by the Special Secretary and shall be given copies of all monitoring instruments.

5.2.3 The Independent Monitor shall revise monitoring tools to reflect revisions to DJS standards under Section 4.1.

5.2.4 To the extent they exist, DJS shall provide the Independent Monitor with copies of any monitoring tools utilized by the Investigations Unit of the DJS Office of Professional Responsibility and Accountability.

5.3 DJS and the Independent Monitor shall share information as follows:

5.3.1 The Independent Monitor may inspect any information that is readily accessible on site at a DJS facility or office upon request, and may make copies at that time, subject to immediately available resources.

5.3.2 The Independent Monitors shall have ongoing access to DJS electronic case tracking and incident reporting and tracking systems at the

Independent Monitor's OCYF and field locations. DJS shall provide hard copies of attachments to incident reports upon the Independent Monitor's request.

5.3.3 DJS shall provide all incident reports, attachments to incident reports, and dispositions not available on the online system to the Independent Monitor on a weekly basis.

5.3.4 DJS shall provide the Independent Monitor with a copy of its monthly summary grievance report as part of the report's routine distribution, and copies of individual grievances and their dispositions upon the Independent Monitor's request.

5.3.5 DJS shall provide the Independent Monitor with copies of all investigative reports relating to youth in facilities within 3 days of each report's completion.

5.3.6 If DJS is required to compile information in order to meet a request of the Independent Monitor, the information shall be provided within 30 days.

5.4 The Independent Monitors shall announce their presence and sign in on the facility's log upon arrival at a facility. The Independent Monitor will be available to confer with the facility administrator at the administrator's request and to advise the administrator of the nature of the visit and the scope of the monitoring visit, as appropriate.

5.4.1 The administrator shall facilitate the cooperation of facility personnel and the identification of documentation to be reviewed, if any. Consistent with the safety and well being of staff and youth and the orderly operation of the facility, the administrator shall ensure that staff and youth are reasonably available to communicate with the Independent Monitor. If DJS staff indicates that an Independent Monitor's visit to a particular area creates a security risk, the Independent Monitor will temporarily leave the area. If DJS staff indicates they are not able to reasonably respond to the Independent Monitor's questions while assisting youth in their normal course of duty, the Independent Monitor may schedule an interview at a time when the staff is not working with youth.

5.5 The Independent Monitor shall immediately report imminent or material threats to the health, life, and safety of youth, staff, or the public to:

- The facility administrator or managing officer, as appropriate, and
- The DJS on call administrator.

5.5.1 At the conclusion of the on-site visit the Independent Monitor shall offer to conduct an exit conference with the facility administrator or managing officer to advise them of any preliminary findings and observations.

5.5.2 The Independent Monitor shall specifically advise the administrator or managing officer of other issues that may have the potential to jeopardize the health, life, or safety of youth, staff, or the public.

5.6 As soon as practicable, DJS shall report imminent or material threats to the health, life, and safety of youth, staff, or the public to the Independent Monitor.

6.0 Reporting.

6.1 The Independent Monitor shall prepare preliminary findings and recommendations to the Secretary of DJS (or designee) on the results of a monitoring visit, including findings and recommendations regarding compliance with standards identified under Section 4.1 and other concerns identified under Section 4.3. The preliminary findings and recommendations shall be submitted and organized as follows:

6.1.1 Findings related to DJS's compliance with standards included in section 4.1 shall be reported in a section entitled "compliance with DJS standards."

6.1.2 Findings related to concerns regarding the adequacy of DJS standards under section 4.3 shall be reported in a section entitled "other monitoring concerns."

6.1.3 Recommendations related to compliance with DJS standards included in section 4.1 shall be reported in a section entitled "recommendations" and in proposed corrective action plan elements appended to the report.

6.1.4 Recommendations regarding options for addressing concerns identified under section 4.3 may be set out in a memorandum to the Special Secretary, as provided in section 7.0.

6.2 The Independent Monitor will submit preliminary reports of findings and recommendations regarding regular, periodic monitoring visits to facilities to DJS on at least a quarterly basis. In addition, the Independent Monitor may submit preliminary reports of specific incidents seriously affecting the care, supervision and treatment of children in facilities that require more timely attention at any time.

6.3 DJS will be permitted 10 work days from the date of hand delivery or facsimile receipt of a preliminary report to deliver a response to the preliminary report findings and recommendations, including suggested corrections or other revisions to the preliminary report and the reasons for those suggested changes. The Independent Monitor may seek further clarification or otherwise discuss the response with DJS. The Independent Monitor may amend the preliminary report to adopt any DJS suggestion, as appropriate. The preliminary report shall be considered a draft during the 10-day comment period.

6.3.1 If the Independent Monitor does not adopt a DJS suggestion, the DJS response to the preliminary report shall be appended to and considered a part of the Independent Monitor's Final Report of Findings and Recommendations. If some of the DJS suggestions are adopted, DJS shall be given the opportunity to deliver a modified response, within 3

workdays from the date of hand delivery or facsimile notice of the Independent Monitor's decision, for inclusion with the Independent Monitor's Final Report of Findings and Recommendations.

6.3.2 If DJS does not deliver suggested corrections or revisions to the preliminary report within 10 workdays, the Independent Monitor's preliminary report shall be forwarded to DJS as the Final Report of Findings and Recommendations.

6.4 The Independent Monitor will send a copy of the Final Report of Findings and Recommendations to DJS, the Subcabinet, the Speaker of the House, and the President of the Senate within 10 workdays after the deadline for receipt of comments to the preliminary report.

6.5 DJS will have 45 days from receipt of the preliminary findings and recommendations to submit a Corrective Action Plan which details corrective actions taken since the date of the on-site visit and corrective actions to be taken, including timelines for completion.

6.6 To enhance the possibility of agreement as to the Corrective Action Plan, the Independent Monitor and DJS shall engage in discussions concerning DJS's proposed Corrective Action Plan.

6.7 Within 90 days of issuance of the Report of Findings and Recommendations, the Independent Monitor shall issue a Comprehensive Monitoring Report. The Comprehensive Monitoring Report shall include: the Final Report of Findings and Recommendations, the Corrective Action Plan and the following addenda, as appropriate:

6.7.1 If the Report of Findings and Recommendations does not adopt the suggestions contained in DJS's response to the preliminary report, it shall include a copy of DJS's response. If some of DJS's suggestions are adopted, DJS shall be given the opportunity to submit a modified response for inclusion with the Comprehensive Monitoring Report.

6.7.2 If DJS and the Independent Monitor have not reached agreement regarding the Corrective Action Plan, the Comprehensive Monitoring Report may include the Independent Monitor's comments on the DJS Corrective Action Plan.

6.8 If the Independent Monitor and DJS have not reached agreement on the Corrective Action Plan within the 90-day period, then the issues in dispute shall be submitted to the Secretary of DJS and the Special Secretary for resolution. However, efforts to resolve disputes under this provision shall not delay the issuance of the Comprehensive Monitoring Report within the 90-day timeline in Section 6.6.

6.9 The Independent Monitor's Comprehensive Monitoring Report shall be distributed to the Secretary of DJS, the Subcabinet, the Speaker of the House, and

the President of the Senate, and be made available in electronic format.

6.10 On the next visit to the facility, the Independent Monitor shall review the status of corrective action on items agreed to by DJS from the prior monitoring reports, in addition to other monitoring activities that may be appropriate.

6.11 All reports issued by the Independent Monitor shall comport with the provisions of this Section and Section 7.0.

7.0 Policy Recommendations.

If the Independent Monitor has recommendations regarding matters to be addressed pursuant to Section 4.3, those concerns or suggestions shall be presented in a memorandum to the Special Secretary. If the Special Secretary deems it appropriate, the Special Secretary may present such matters to the Secretary of DJS and the Subcabinet.

8.0 Confidentiality.

8.1 The Independent Monitor shall conduct the monitoring process and reporting consistent with applicable confidentiality laws, including, but not limited to, Maryland Annotated Code, Courts and Judicial Proceedings Article, § 3-8A-27, Article 83C, Article 88A, §6A, and Article 49D.

APPENDIX D
Flow Chart

Independent Monitoring and Reporting Process

Based on HB 971, Article 49D and agreed upon SOP from November 3, 2003

VISIT MADE BY INDEPENDENT MONITOR

Life, Health, Safety Findings (LHS)
Existing Standards (COMAR, DJS standards & policies/procedures, contracts w/vendors)
(4.0) Other Monitoring Concerns (4.3)

LHS - Serious Incident - Monitor feels there is imminent danger to youth.

LHS - Verbal report made to facility administrator or managing officer and DJS on-call administrator (5.5)

LHS - Special Timely Report sent to Secretary of DJS

Also sent to DJS ensure report is received by all appropriate staff. INTERNAL ONLY GOC Executive Director, Dep. Sec, AG, PIO

Preliminary Findings and Recommendations sent to Secretary of DJS at end of quarter (6.1)
This report is referred to by IM as a DRAFT during this period (6.3)

Also sent to DJS to ensure report is received by all appropriate staff. INTERNAL ONLY
GOC Executive Director, Dep. Sec, AG, PIO

DJS has 10 working days from receipt of Preliminary Report to respond to IM. (6.3)

- IM reviews DJS response
- Discusses response with DJS for clarification if necessary

If IM **does not** amend report, DJS response is appended to IM report & is considered part of the IM *Final Report of Findings and Recommendations* (6.3.1)

If **some** of DJS response is adopted, DJS has 3 working days from notice from IM of this change to provide IM with a modified response to be included in *Final Report of Findings and Recommendations* (6.3.1)

Final Timely Report issued by IM – detailed report for each facility covering the quarter.

DJS has 45 days from receipt of the ***Preliminary Findings and Recommendations Report*** to respond with a Corrective Action Plan (CAP) (6.5)

Sent to Secretary of DJS and designated staff to ensure report is received by all appropriate DJS staff; facility administrators; Senate President, Speaker of House; 10 copies Legislative Services (5 redacted, 5 not redacted) GOC Executive Director, Dep. Sec., AG, PIO

CAP received by IM; discussion with DJS; opportunity for DJS to amend CAP; *Comprehensive Monitoring Report* is issued within 90 days of DJS' receipt of ***Preliminary Findings and Recommendations*** (6.5, 6.6, 6.7, 6.8, 6.9)

Quarterly Report issued by IM – summary of *Final Timely Report* that also includes DJS' responses to findings. Posted on GOC website.

Sent to all the above *and* State Advisory Board for Juvenile Justice

Annual Report
November 30 each year

State Advisory Councils and Governor
Posted on GOC website

APPENDIX E
Amended Baltimore County Interagency Agreement on the Investigation of Child Abuse and Neglect at the Charles H. Hickey School

AMENDED BALTIMORE COUNTY INTERAGENCY AGREEMENT ON THE INVESTIGATION OF CHILD ABUSE AND NEGLECT AT THE CHARLES H. HICKEY, JR. SCHOOL

I. GENERAL

The purpose of this Baltimore County Interagency Agreement on the Investigation of Child Abuse and Neglect at the Charles H. Hickey, Jr. School (agreement) is to provide and promote coordination and communication among the participating agencies in the investigation of allegations of child abuse and child neglect at the Charles H. Hickey, Jr. School and in any subsequent personnel actions or criminal prosecutions which might arise from such investigations. The goal of this agreement is to provide the best possible outcomes for children and the community. The parties agree to follow a common protocol for investigating allegations of child abuse and child neglect, to commit resources necessary to achieve common goals, to seek to resolve differences that arise between or among agencies, and to place the welfare of children first.

The participating agencies in this Agreement are the Baltimore County Department of Social Services (DSS), the Maryland State Police (MSP), the Office of the State's Attorney for Baltimore County (SAO), the Maryland Department of Juvenile Services (DJS), the Maryland State Department of Education (MSDE), and the Governor's Office for Children (GOC).

- DSS is responsible for conducting Child Protective Services (CPS) assessments of allegations of suspected child abuse and neglect at the Charles H. Hickey, Jr. School. DSS shall designate specific staff with appropriate skills and training to conduct these assessments.

- MSP is responsible for conducting criminal investigations of suspected child abuse at the Charles H. Hickey, Jr. School. MSP shall designate detectives with appropriate skills and training to conduct these investigations.

- SAO is responsible for the prosecution of criminal charges arising from investigations of suspected child abuse and neglect at the Charles H. Hickey, Jr. School.

- DJS is responsible for administrative investigations and for the care and welfare of the young persons in its legal custody at the Charles H. Hickey, Jr. School.

- MSDE is responsible for providing educational services at the Charles H. Hickey, Jr. School. MSDE shall designate specific staff with appropriate skills and training to provide educational services

and shall take appropriate personnel action regarding its staff or contractors in response to investigations of child abuse or neglect.

- GOC is responsible, through its Independent Juvenile Justice Monitor, for general oversight of the welfare of children in the custody of DJS, including residential students at the Charles H. Hickey, Jr. School.

II. CHILD ABUSE

The Initial Report.

DSS and MSP shall maintain 24-hour coverage for receiving reports of **all** suspected child abuse.

DSS and MSP shall immediately share with each other all information/ notifications of suspected child abuse. Whenever either party receives a report, whether from an outside source or from the other, both parties shall also notify the Independent Juvenile Justice Monitor and DJS as soon as possible.

If the allegation involves an MSDE staff member, the MSDE principal or designee assigned to the Charles H. Hickey, Jr. School shall be notified and issued a copy of the initial DJS incident report within 24 hours of the reported incident.

The Independent Juvenile Justice Monitor and MSP shall also be notified by either DSS or DJS of any reports of alleged inappropriate conduct directed towards students at the Charles H. Hickey, Jr. School, even if such incidents do not meet the technical requirements of child abuse. An example would be an alleged assault by a Hickey School staff member against a student who is 18 years old or older. MSP shall promptly notify SAO of any criminal investigations arising from such circumstances.

DJS shall assist DSS, MSP and MSDE in obtaining basic information regarding the victim and the alleged perpetrator.

The Investigation

All child victims shall be seen within 24 hours by the MSP, and/or DSS.

DSS and the MSP shall conduct joint investigations of suspected child abuse to the fullest extent circumstances permit. There shall be full sharing of information between the respective investigators. Whenever possible, the specialized investigators from DSS, MSP shall make a joint initial on-site response at the Charles H. Hickey, Jr. School.

If the alleged abuser is an MSDE staff member, DJS shall notify MSDE, whenever possible, of the time and date of the DSS and/or MSP interview with the

staff member and victim and, if possible, attempt to coordinate the time of the interview so that an MSDE investigator may be present at the facility. If the staff member and/or victim's parent, guardian or caregiver provides consent, the interviews may be audiotaped and/or videotaped. In the case of allegations of sexual misconduct against an MSDE staff member, all reasonable efforts will be made for the interviews to be conducted at the DSS and to arrange for the victim and any minor witnesses to be transported to and from the facility by the MSP. It will be the joint decision of DSS and MSP whether videotaping or audit taping is impractical or clinically or forensically inappropriate or contrary to the best interest of the youth.

If MSDE or DJS need to conduct interviews separate from those conducted by DSS and MSP a multi-disciplinary staffing that includes representatives of DJS, MSDE, DSS, and SAO shall be immediately held to share information and determine whether additional interviews of victims, staff or witnesses is appropriate or necessary. Regardless whether additional interviews are necessary all cases involving MSDE or DJS personnel shall be subject to a multi-disciplinary staffing within 30 days of the initial report to enable MSDE or DJS to take appropriate personnel action.

MSP patrol officers shall respond on-site to the Charles H. Hickey, Jr. School when necessary and after normal business hours to meet the mandate for 24-hour response.

In the event of serious injury after normal business hours, the MSP patrol officer shall notify an MSP detective who shall notify DSS through the DSS After Hours Service emergency telephone number. An MSP detective and the DSS social worker assigned to After Hours Service shall respond to the Charles H. Hickey, Jr. School to begin the investigative process. A specialized investigator from DSS shall take over the CPS portion of the investigation on the next business day.

DJS on-site investigators shall make medical, social and other relevant information under its control available to DSS and MSP investigators.

If the alleged perpetrator of the abuse is an MSDE employee or contractor, the DSS shall inform the MSDE Assistant State Superintendent of education or his or her designee immediately of the investigation. MSDE shall ensure that steps are immediately taken to remove the alleged abuser from direct contact with the victim and other children as necessary pending completion of the investigation. Further, DJS and MSDE shall take all necessary steps to protect the victim and any witnesses.

DJS shall assist in interviewing victims and suspects and gathering of relevant information from the facility at the direction of MSP, and/or DSS investigators. This may include taking photographs of alleged victims and/or alleged perpetrators.

DJS shall ensure that the victim receives appropriate medical and/or mental health treatment.

Whenever possible, DSS, and MSP shall coordinate all subsequent investigative interviews of victims, alleged perpetrators and other persons relevant to the investigation.

MSP, DSS and DJS may consult with SAO if they believe that criminal or juvenile delinquency charges may result, or should result, from any incident under investigation at the Charles H. Hickey, Jr. School.

III. CHILD NEGLECT

The Initial Report

DSS shall maintain 24-hour coverage for receiving reports of suspected child neglect.

DSS shall notify the Independent Juvenile Justice Monitor of GOC and DJS of any report it receives alleging neglect of a student at the Charles H. Hickey, Jr. School as soon as possible.

The Independent Juvenile Justice Monitor shall also be notified by DSS, MSP, MSDE or DJS of any reports of alleged inappropriate conduct directed towards students at the Charles H. Hickey, Jr. School, even if such incidents do not meet the technical requirements of child neglect.

DJS shall assist DSS in obtaining basic information regarding the victim and the alleged perpetrator.

The Investigation

All child victims shall be seen within 5 days by DSS.

Whenever possible, DSS shall assign specialized staff to conduct CPS investigations at the Charles H. Hickey, Jr. School beginning with the initial on-site response.

DJS on-site investigators shall make medical, social and other relevant information under its control available to DSS.

If the alleged perpetrator of the neglect is an MSDE employee or contractor, DSS shall inform the MSDE Assistant State Superintendent of education or his or her designee immediately of the investigation. MSDE shall ensure that steps are immediately taken to remove the alleged perpetrator from direct contact with the victim and other children as necessary pending completion of the investigation. Further, MSDE and DJS shall take all necessary steps to protect the victim and any witnesses.

If the alleged perpetrator of the neglect is an MSDE employee or contractor, DSS and DJS shall attempt to coordinate the date and time of the interview with the staff

member and victim so that an MSDE investigator may be present at the facility. If the staff member and/or the victim's parent, guardian or caregiver provides consent, the interviews may be audiotaped.

If MSDE or DJS need to conduct interviews separate from those conducted by DSS, a multi-disciplinary staffing that includes representatives of DJS, MSDE, and DSS shall be immediately held to share information and determine whether additional interviews of victims, staff or witnesses is appropriate or necessary. Regardless whether additional interviews are necessary all cases involving MSDE or DJS personnel shall be subject to a multi-disciplinary staffing within 30 days of the initial report to enable MSDE or DJS to take appropriate personnel action.

DJS shall assist in interviewing of victims and suspects and in the gathering of relevant information from the facility at the direction of DSS. This may include taking photographs of alleged victims and/or alleged perpetrators.

DJS shall ensure that victims receive appropriate medical and/or mental health treatment.

DSS and DJS may consult with SAO and MSP if they believe that criminal or juvenile delinquency charges may result, or should result, from any incident under investigation at the Charles H. Hickey, Jr. School.

IV. MULTI-DISCIPLINARY TEAM MEETINGS AND THE SHARING OF INFORMATION CONCERNING CHILD ABUSE AND CHILD NEGLECT INVESTIGATIONS.

Every investigation of child abuse and neglect at the Charles H. Hickey, Jr. School shall be reviewed at a Multi-Disciplinary Team meeting. The purpose of the Multi-Disciplinary Team meeting is to share information regarding the progress and/or results of the investigation.

All parties to this Agreement are standing members of the Multi-Disciplinary Team for child abuse and neglect investigations at the Charles H. Hickey, Jr. School. DSS, MSP, DJS and MSDE staff with direct knowledge of an investigation shall attend the Multi-Disciplinary Team meeting for the investigation, unless such staff member is the alleged child abuser or child neglector.

GOC shall receive a copy of the DSS investigative report at the conclusion of the DSS investigation. Under current practice, the DSS report is given to the Independent Juvenile Justice Monitor at the Multi-Disciplinary Team meeting and another copy is sent to the Director of the Office of the Independent Juvenile Justice Monitor at GOC.

V. FORMAL CHARGES AND PROSECUTION

SAO will have an Assistant State's Attorney available on an on-call basis for consultations on all cases involving child abuse at the Charles H. Hickey, Jr. School, which are being mutually investigated by MSP, and DSS.

Whenever possible, MSP **or** shall consult with SAO prior to arresting a suspect in connection with a child abuse or other criminal matter involving students at the Charles H. Hickey, Jr. School.

Upon arrest of a suspect in any child abuse case, MSP, and DSS may contact SAO and advise of any appropriate conditions of bail, which SAO should recommend to the judge conducting the bail review hearing for that suspect. SAO will make such recommendations concerning bail, provided such requests are timely and appropriate.

SAO shall maintain a separate unit known as the "Sexual Offense and Child Abuse Division" which will be responsible for the screening, formal charging, and assignment of all child abuse cases arising at the Charles H. Hickey, Jr. School. In addition, the SAO Division Chief will be available for consultation with MSP, and DSS regarding the decision as to whether to file formal charges in any child abuse case, which is being investigated.

DSS and MSP shall make every reasonable effort to have investigative reports completed and forwarded to the SAO in a timely manner – within 60 days if possible. DSS, MSP, and DJS shall provide the SAO with a summary of the investigation at the conclusion of each respective agency's investigation.

The SAO Division Chief or his/her designee shall present those cases involving child abuse, which have been scheduled for presentment before the Grand Jury. After formal charges have been filed in any child abuse case, the Division Chief will either keep the case himself/herself or specially assign the case to an experienced Assistant State's Attorney who will be responsible for the handling of the case through disposition.

In order to spare the alleged victim additional trauma, the Assistant State's Attorney will not interview an alleged victim of child abuse unless the case is reasonably certain to go to trial on the merits. In the event a child abuse case is reasonably certain to go to trial on the merits, the Assistant State's can be present to assist during the interview of the alleged victim. DSS and MSP will be available to assist the Assistant State's Attorney in any child abuse case with matters pertaining to the interview of the alleged victim, the marshaling of evidence and information regarding the results of investigations as well as the joint resolution of any problems regarding the location and transportation of the alleged victim to court for Attorney handling the case will notify DSS, when necessary, so that the appropriate social worker the trial of the case. DJS, as the agency with care or custody of the alleged victim at the time of the incident will assist in these activities at the direction of DSS, MSP and/or SAO.

VI. TRAINING PROGRAM

Each of the parties to this Agreement is committed to providing specialized training that relates to the field of child abuse and neglect, including, when possible, training that relates to institutional abuse and neglect. The respective parties shall insure that the other parties to this Agreement are aware of available training opportunities.

VII. APPEAL PROCESS

Each of the parties to this Agreement shall provide to the other agencies the resources required to support an agency personnel, abuse or neglect decision on appeal to the Office of Administrative Hearings, including making available necessary testimonial and documentary evidence in the control or custody of the party.

VIII. DATA REPORTING

The parties agree to share necessary statistical data on a quarterly basis. The DSS shall specifically provide to DJS statistical data on screened out cases on a quarterly basis.

APPENDIX F
Quarterly Report for April – June 2006

MONITORS' ASSESSMENTS OF FACILITIES AND THE DEPARTMENT OF JUVENILE SERVICES RESPONSE
Quarterly Report: April - June 2006

The BALTIMORE CITY JUVENILE JUSTICE CENTER (BCJJC) is a State detention facility that has the capacity to *safely* house 72 youth; however, once a suicide resistant barrier is constructed for the second tier, the facility will be able to safely house its designed capacity of 144 youth. The Maryland State Department of Education provides instruction to the youth at the facility.

STAFFING:

Unabated for 30 or More Days:

- Population:

The facility is rated for a maximum population of 144 and although DJS data indicates the population averaged approximately 144 during this quarter, this monitor observed populations from 136 to 162. Administration has drafted a procedure that formally utilizes the infirmary, intake area, interview room and open area of the unit for sleeping up to 24 extra youth and use of the gymnasium if it became absolutely necessary.

Unabated for 30 or More Days:

- Staff/Youth Ratios:

Overtime staff are being used to maintain a 1:6 staffing ratio. On 6/8/06, this monitor observed the Unit Roster Count Sheets from the 6 to 7AM time period. There were 2 staff on each unit except for 4 of the units that had only 1 staff – each with 12 youth.

Unabated for 30 or More Days:

- Master Control Staffing:

Staff in master control were observed as very professional and efficient; however, there continues to be a need for more personnel to reduce the stress placed on a single staff working in master control. Master control staff must deal with the security system (cameras and doors), radio, phones and visitors/staff requesting assistance outside the master control area (at the window), logs and population movement. The floor control room is often not manned due to limited staffing and that places additional responsibilities on the master control staff.

- Staff Training:

Child Abuse Recognition and Reporting Training:
In-service training was provided to 7 employees on May 9.

Unabated for 30 or More Days:

- Child Abuse Interagency Agreement and Restraint Training:

There is still no agreement in effect and no trainings have taken place for DSS, DJS and Police investigators relating to the proper use of restraints in DJS facilities.

Response:
The MOU has been completed and is being distributed for signatures.

Unabated for 30 or More Days:

- Identification and Professionalism:

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

Response:
We are working on eliminating the delays in having the photographs completed for staff. This particular situation is beyond the control of DJS.

SAFETY AND SECURITY:

- Escape Incident:

On 5/24, there was an escape from the facility when a youth exited his unit to the outside recreation area via an unsecured door, climbed onto the roof and jumped off onto the street below (See ICAU Number 39028). DJS/ICAU conducted a comprehensive investigation and sustained violations against staff for neglect of duties. There were problems with the video cameras recording the escape and synchronizing the times of the escape. Technology personnel from DJS were addressing the problems immediately.

- Monitoring Unsecured Doors in Master Control:

Unsecured doors currently are displayed on the master control monitor as red and secured doors are green. It would be very helpful if the red unsecured doors flashed to draw attention to the problem. The technology department is also working on synchronizing cameras with open doors so that the camera focuses on the particular area of concern until the door is secured.

Unabated for 30 or More Days:

- Detention/Pending Placement Youth:

According to the facility's Population Reports, on 5/4/06, there were 53 youth on "pending placement." Of those youth, 10 had been there longer than 60 days, 5 of those youth had been there longer than 100 days and one of those youth had been there longer than 200 days. There were 92 youth in "detention." Of those youth, 2 had been there longer than 60 days. On 6/7/06, there were 35 youth on "pending placement." Of those youth, 23 had been there longer than 60 days and 7 of those youth had been there longer than 100 days. There were 114 youth in "detention." Of those youth, 5 had been there longer than 60 days and 1 had been there more than 100 days. It appears that more youth were spending longer periods on pending placement and in detention towards the end of the quarter. See the incident in the "Aggressive Incidents" section of this report that describes an assault on staff committed by a youth who had been in custody at the facility since 1/20/06.

Response:
DJS will continue to actively work with the Juvenile Detention Alternatives Initiative representatives, Public Defenders, States Attorneys, parents and the Court to reduce length of stays for pre and post adjudicated youth. All stakeholders will explore possible alternatives to detention.

Unabated for 30 or More Days:

- Abuse Incidents:

On 5/23, two staff persons were involved in a confrontation with a youth that led to an alleged child abuse and injuries to the youth (ICAU Number 39010). Both staff were terminated as a result of a DJS/ICAU investigation.

On 6/1, a youth reported to a counselor at his out–of-state placement that a staff at BCJJC sexually abused him in February (See ICAU Number 39332). An investigation into the incident revealed that the allegation occurred at Cheltenham Youth Facility in P.G. County. CPS and MSP have been notified and DJS/ICAU did not sustain any violations.

- Aggressive incidents rose from 245 incidents last quarter to 310 this quarter

  - On 4/18/06 one youth was assaulted by five other youth while on the unit. He received injuries to his head, eye and nose and was transported to University Hospital (See ICAU Number 38171).
  - On 4/21, a youth jumped over the serving line counter in the dining hall and struck a cooking staff in the face with his fist (See ICAU Number 38318). DJS and the State Police are investigating the incident as a possible "gang initiation." The youth who "influenced" the assailant to commit the crime had been placed in seclusion on 4/16 for attempting to instruct another youth in gang activity communication signs (See ICAU Number 38104).
  - On 4/21, a youth assaulted a staff by striking him in the head with a broom handle and as the staff person attempted to restrain the youth, another youth assaulted him by jumping on his back (See ICAU Number 38380). The broom handle was found the next evening in another youth's room (ICAU Number 38277).

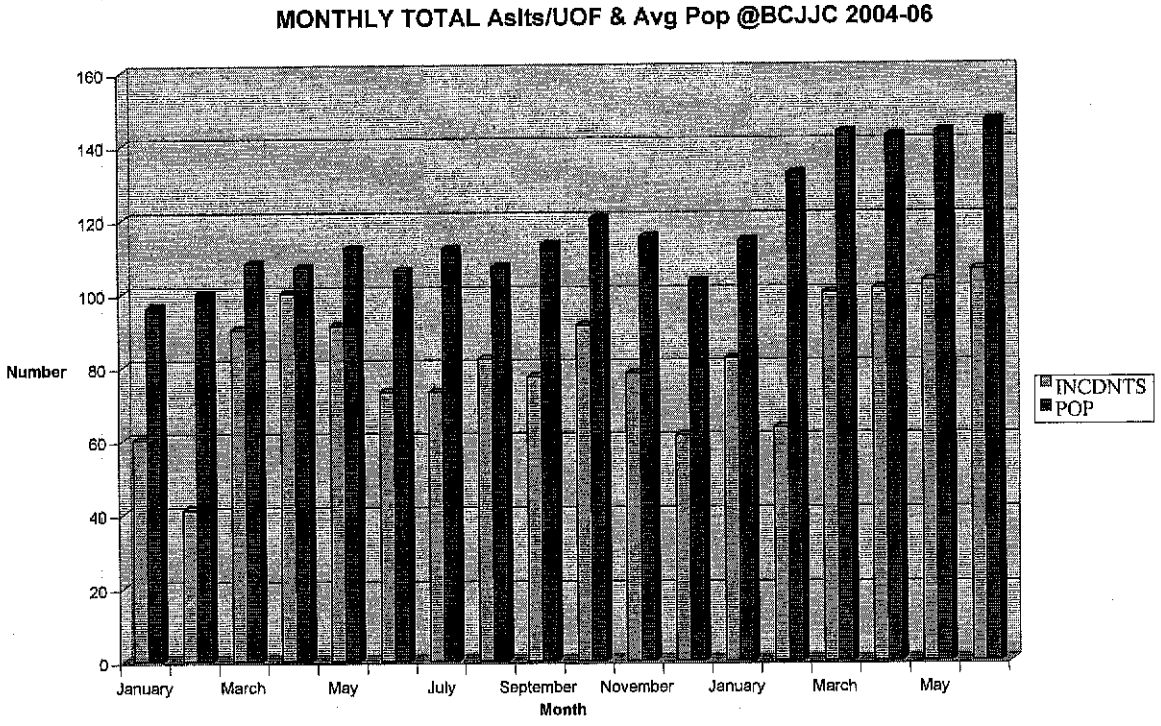
According to the DJS Incident Report database, the following incidents have been reported at BCJJC from 2005 through 2006. Also included is the DJS average monthly population:

	Y on Y Aslt/Riot	Y on S Aslt	CHAB	UOF	**TOTALS**	Avg.# 0f Assaultive Incidents Per Day	Avg Pop
January	36	3	0	21	**60**	**1.9**	96
February	30	2	1	8	**41**	**1.5**	100
March	52	18	1	19	**90**	**2.9**	108
April	55	15	0	30	**100**	**3.3**	107
May	47	19	1	24	**91**	**2.9**	112
June	43	12	0	18	**73**	**2.4**	106
July	41	17	0	15	**73**	**2.4**	112
August	47	11	0	24	**82**	**2.6**	107
September	45	4	0	28	**77**	**2.6**	113
October	39	14	0	38	**91**	**2.9**	120
November	39	4	0	35	**78**	**2.6**	115
December	34	7	1	19	**61**	**2**	103

January	39	7	0	36	**82**	**2.6**	114
February	36	4	0	23	**63**	**2.3**	132
March	50	10	0	40	**100**	**3.2**	143
April	40	10	0	51	**101**	**3.4**	142
May	66	6	0	41	**103**	**3.3**	143
June	59	7	0	40	**106**	**3.5**	146
TOTALS	**798**	**170**	**4**	**510**	**1472**	**2.68**	**118**

Key: Y on Y Aslt = Youth on Youth Assaults; Y on S Aslt = Youth on Staff Assaults
CHAB = Sexual and Physical Child Abuse Incidents; UOF = Use of Force

The following graph is based on the above information:



Unabated for 30 or More Days:

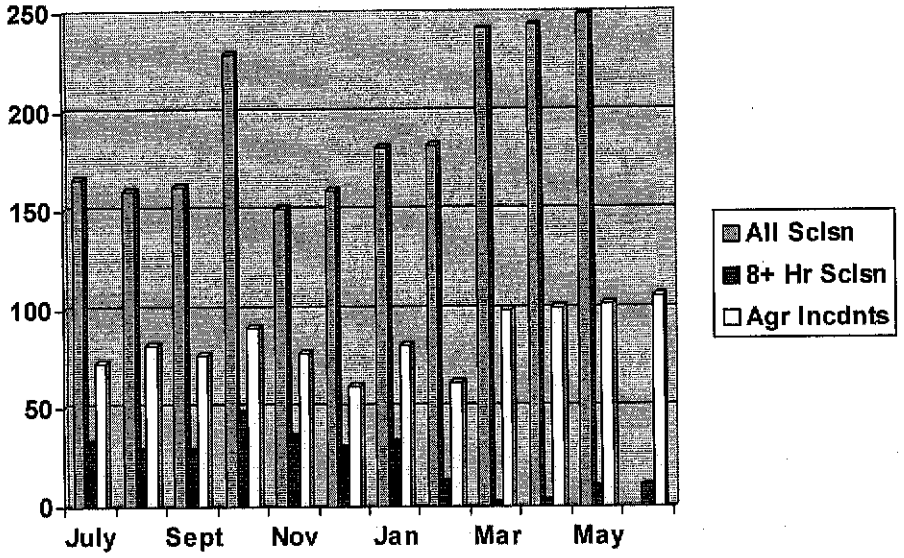
- Use of Seclusion:

Use of seclusion remains high, although there appears to be no effect in reducing the number of aggressive incidents as indicated below.

Reported Incidents for the Use of Seclusion:
According to the Seclusion Log in Master Control, there were:

- 230 in October,
- 151 in November
- 160 in December through 12/28/05
- 182 in January, 2006
- 183 in February
- 242 in March
- 244 in April
- 249 in May

Reported incidents of youth being placed in ***locked door seclusion for more than 8 hours*** (ICAU Incident Report Database) declined again from 47 last quarter to 24 this quarter. To determine the effect of seclusion on the number of assaults and aggressive type incidents see the following chart. The following chart indicates the number of **All Seclusions (including less than 8 hours), Locked Door Seclusion for More than 8 hours** and **Aggressive Type** incidents that have been entered in the Seclusion Log and ICAU Incident Report Database for July 2005 through April of 2006.



It appears that although the use of 8+ hour seclusion was reduced from last quarter to this quarter, it still rose slightly from April to June, the population steadily increased and the number of aggressive incidents increased. The use of seclusion alone cannot be deemed effective for reducing violent/aggressive incidents. The facility should be commended for reducing the number of reported incidents for 8+ hour seclusion; however, the increase in all seclusions and aggressive incidents still indicates a need for more effective crisis intervention.

Response:

1. Conflict Resolution/Peer Mediation Program will continue to assist the facility with mediating conflicts between youth.
2. All incident reports will be reviewed by managers to determine root causes for altercations.
3. Staff will receive training on crisis prevention management, child abuse and neglect training.

Unabated for 30 or More Days:

- Inaccuracies in Seclusion Log:

On 5/13/06, this monitor observed entries in the Seclusion Log and noted on page 27030 that an entry was out of order – indicating it was written in late. There was an entry for 5/2 then there was an entry for 4/30, and then five for 5/1.

Response:
Staff will receive refresher training on completion of incident reports and supervisors will receive training on completing the seclusion log book.

Unabated for 30 or More Days:

- Suicide Related Incidents and Barrier:

Suicide related incidents declined from 9 last quarter to 4 this quarter. There was a decrease in suicide behavior from 3 incidents last quarter to 1 incident this quarter. Suicide gestures decreased from 5 last quarter to 0 this quarter but suicide ideations rose from 1 last quarter to 3 this quarter. However, there is still no suicide resistant barrier on the second tier of the facility. A meeting with DJS, the architect and this Office was held on 6/15 and this Office was informed that construction should begin at the end of August.

Response:
This project commenced on August 16, 2006 and is anticipated to be completed in 90 days.

- Illegal Paraphernalia and Weapons:

The possession of illegal contraband in the facility remained rather high. There were 5 incidents in the last quarter of 2005, 15 last quarter and 14 this quarter. Staff should be commended for locating the contraband; however, there should also be a concentrated effort to prevent the contraband from entering the facility or the youth's possession in the first place.

- Suspected Illegal Drugs:

On 6/21/06 a youth reported to another facility for placement and he stated that he had received suspected marihuana and smoked it with another youth at BCJJC on 6/18 (See ICAU Number 39902). DJS and the Maryland State Police are investigating.

Response:
Shakedown searches occur on a daily basis. Facility shakedown searches occur at least monthly. These searches are assisting the facility in reducing the amount of contraband in the facility.

- Stolen Property from Property Room:

On 4/19/06, a youth's cell phone, watch and approximately twenty-eight dollars in cash were reported stolen/missing from the intake property room of the facility (See ICAU Number38222). DJS and the Maryland State Police initiated an investigation and the youth was reimbursed for the stolen/missing property. On 4/24, this monitor observed staff and supervisors conducting an inventory of the property room and the facility administrator explained that procedures for processing the youths' property was changing so only specific supervisors and administrators had keys to the property room.

Response:
The Office of Professional Responsibility and Accountability will investigate staff misconduct and the appropriate disciplinary action will be imposed on staff in violation of policy, procedure or Standards of Conduct.

- Outside Recreation Area Cameras:

On 5/5/06 the lens covers on the cameras in the recreation yard were observed falling off. See Maintenance Issues.

Response:
Cameras have been repaired. The information technology department will be notified when a camera is in need of repair. This will be accomplished with the submission of a work order.

- Unsecured Door:

On 5/5/06 this monitor was touring the facility with the Assistant Facility Administrator (AFA) and one of the doors to the orientation pod was observed unsecured. The AFA secured the door immediately and explained that staff must pull doors closed and not rely on the self-closing mechanisms.

Response:
All staff have been instructed and directed to secure all doors in the facility and to ensure that all doors remain secure at all times. The master control room operator will monitor the control room panels to determine if any door is showing as unsecured. If this occurs, staff will be notified and the door will be secured. Shift commanders and/or resident advisor supervisors will make periodic checks during their shift to check to make sure doors are secured.

EDUCATION:
Unabated for 30 or More Days:

- Classroom Overcrowding:

MSDE staff continued to express concern that the population has risen in some of the classroom periods. This crowding problem will be partially addressed when the second floor is renovated for the education department; however, more teachers are still required to meet the needs of this population. Some of these concerns should be addressed when the second floor of the facility is renovated to accommodate education.

Response:
Classroom sizes have been decreased to acceptable levels. BCJJC Superintendent and MSDE Principal added three additional classrooms for educational instruction. The expansion of the MSDE School is in the planning stages

- Vocational training:

On 5/5, this monitor observed vocational training utilizing models of electrical connection boards and drafting. Staff advised that the youth who had participated in the instruction appeared very engaged.

- IEP Meeting:

On 6/8/06, this monitor observed an Individualized Education Program (IEP) meeting for a special education youth and noted that the youth's parent and case manager were not present as is preferred but they had been notified as required by policy. The IEP coordinator advised that it is often difficult to have the parent and or the DJS caseworker attend the meetings.

Response:
Schedules of IEP meetings are provided to all vital stakeholders and parents are notified by the education department. Invitations are extended as required by law.
Attendance is monitored by the Principal.

PROGRAMMING:

- Consistency in Controlling Behavior of Youth:

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

- Outside Meals in the Facility Courtyard:
  Some youth have been rewarded for their positive behavior with eating dinners in the center courtyard of the facility.

- Positive youth who reach the higher levels of behavior are receiving incentives such as special food, movies, later bed, etc…

- Sixty eight youth attended a program by former L.A. gang member Aqeela Sherrills who was instrumental in developing an historic truce between the Bloods and the Crips in the1992 aftermath of the Rodney King uprisings. Sherrills discussed his own abuse as a child and how he lost his oldest son to gang violence.

HEALTH/MEDICAL:
No significant concerns in this area.

FACILITY AND MAINTENANCE:

Unabated for 30 or More Days:

- Lack of a suicide resistant barrier on the second tiers.

There is still no barrier to prevent youth on the second tiers from attempting to hang themselves. This office attended a meeting on 6/15/06concerning the covering of the railings and the project will reportedly begin in late August.

Unabated for 30 or More Days:

- There is still no barrier between food service personnel and the youth in the serving line in the dining hall. A meeting with DJS on 6/15, discussed completing this project when the suicide resistant barriers are installed. On 4/21, a youth did in fact leap over the serving line counter and strike a cooking staff in the face with his fist (See ICAU Number 38318).

Response:
The construction of the food service barrier system is being planned and funding is being secured by DJS.

Unabated for 30 or More Days:

- Carpeting still needs to be replaced on several units.

Response:
Funding for this project has been identified and the procurement and bidding process has commenced.

- Outside Recreation Area Cameras:

On 5/5/06 the lens covers on the cameras in the recreation yard were observed falling off.

Response:
Cameras have been repaired. The Information Technology department will be notified when a camera is in need of repair. This will be accomplished with the submission of a work order.

ADVOCACY, INVESTIGATIONS AND MONITORING:
Unabated for 30 or More Days:

- Grievances:

This monitor has still not received any DJS monthly grievance summaries from ICAU. This request has been made repeatedly to determine if summaries were completed from November 2002 until April of this year when DJS decided they were no longer completing grievance summaries.

Unabated for 30 or More Days:

- Child Abuse Investigation Interagency Agreement:

A written interagency agreement has not been finalized for responding to child abuse and major incidents at the facility.

Response:
This issue is addressed in each report; there are no monthly grievance summaries to submit.

Unabated for 30 or More Days:

- Inaccurate Reporting:

Several reports throughout the reporting period were improperly labeled.

Response:
Staff will receive refresher training on completion of incident reports

- Citizen's Advisory Board:

This monitor attended a Citizen Advisory Board meeting on 5/13/06. The meeting was well attended from the community and it provided a very good forum to explain our office's mission. There were also some very encouraging signs that the Community Family and Resource Center (CFRC) has been active and plans to become even more active with services, community connections, etc... for youth who have been arrested and/or detained in Baltimore City. Here are some examples of upcoming projects:

A Family Health Fair is planned for the summer in the BCJJC gym. There will reportedly be an extensive collaborative effort from the community, Johns Hopkins, DJS,

DHMH, Baltimore PD, radio station 92Q, local vendors where the youth are being placed, and local health experts. Issues to be addressed are: Mental Health, Substance Abuse, Dental/Somatic Health, Family Health, Gang Violence and personal hygiene. It was suggested that DSS become involved to educate the community on child abuse and neglect issues as they relate to delinquency. There may also be an opportunity for a DJS job fair at the same time.

A project entitled "Know Your Rights" is being spearheaded through the Baltimore City Public Defender's Office and will be focused on providing arrested/incarcerated youth a thorough knowledge of their legal rights. It was suggested that the DJS Child Advocates be involved also.

Also in the summer, BCJJC will reportedly be collaborating with MSDE, students from Morgan University, Coppin State and several other local colleges to focus on mentoring, tutoring and placement issues. There was also a meeting scheduled for the end of May to discuss bridging the efforts of education in the City school system with education at BCJJC to facilitate transition between the two systems. It was suggested that Baltimore PD also come on board with truancy enforcement issues.

- Monitoring:

On June 28, 2006, it was reportedly announced at a DJS Superintendent's meeting that the Department was initiating a new policy with regard to the Office of the Attorney General Juvenile Justice Monitoring Unit. The new policy requires that the supervisor on duty at any DJS facility escort the monitor on his or her visit through the facility. Further it was stated that the monitor was not to interview a staff member without the supervisor present, and that youth were to be interviewed with the supervisor nearby. This policy compromises the ability of the monitor to gather crucial information that may lead to the discovery of concerns that affect the safety and security of youth. It is the expression of staff interviewed, including supervisory staff members, that the perception of this policy is to inhibit staff and youth from divulging any information that might reflect poorly on DJS. Not only does this policy present the perception of impropriety but, is in addition, a violation of the Department's own standard.

Response:
Privacy will be afforded to Independent Monitors when interviewing youth at the facility. Management and/or supervisory staff will escort the monitor throughout the facility to identify staff to the independent monitor and to address any issues, concerns or questions that the monitor may have during his visit to the facility.

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

STAFFING:

- Population:
  The number of youth in detention has decreased from an approximate average of 85 youth during last quarter to approximately 82 youth during this quarter.

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

Unabated for 30 or More Days:

- Insufficient Facilities for Staff:
  On 4/27/06 this monitor observed 3 facility case managers on Roosevelt Hall and they had access to only one computer and two telephones. This concern was addressed in last quarter's report when this monitor observed four facility case managers crowded into one room on Clinton Hall with only 1 phone and 1 computer available for their use.

Response:

There are two case managers assigned to each unit and each person has been assigned a computer and a telephone.

Unabated for 30 or More Days:

- Staff Misconduct:

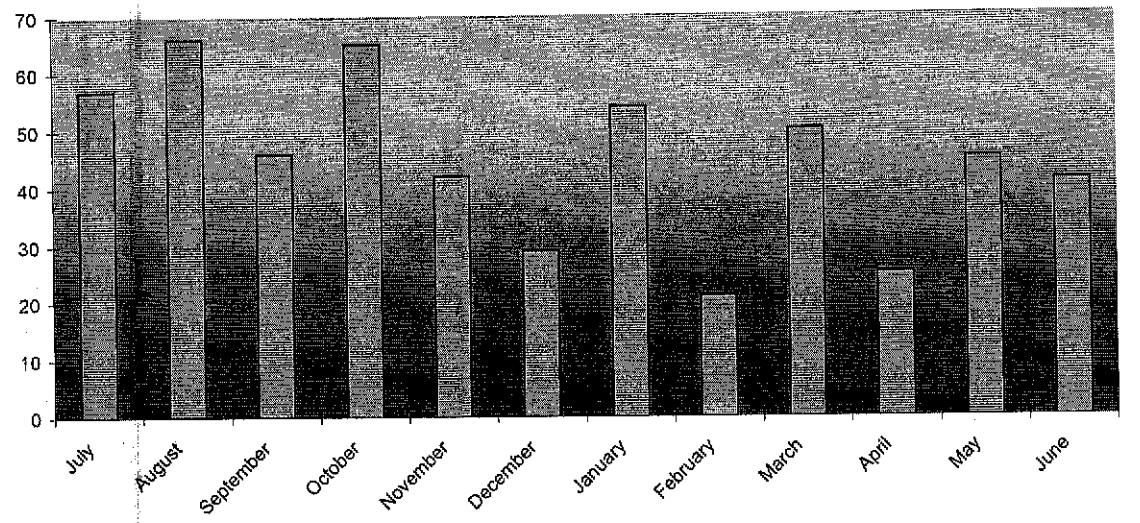
Several cases of misconduct are identified in the Safety and Security area of this report. Very thorough DJS/ICAU investigations were conducted on these incidents.

According to the DJS Incident Report database, the average number of assaultive incidents per day decreased from 1.4 per day during last quarter to1.2 per day during this quarter. There appears to have been a substantial reduction in reports for both aggressive incidents and child abuse/neglect cases; however, it must be noted that several reports from June were logged into the database system in July, more than a week after they occurred.

The source data for the following chart was extracted from the ICAU/DJS database and encompasses July 2005 through June 2006 for a 12 month comparison. It must be noted that some of these incidents have resulted in child abuse/neglect investigations that are not accurately reflected in these totals:

July	25	7	0	25	**57**	**1.8**
August	31	9	0	26	**66**	**2.1**
September	22	13	1	10	**46**	**1.5**
October	36	9	1	19	**65**	**2.1**
November	16	11	0	15	**42**	**1.4**
December	13	0	0	16	**29**	**0.9**
January	28	4	1	21	**54**	**1.7**
February	13	2	0	6	**21**	**0.8**
March	28	3	0	19	**50**	**1.6**
April	15	0	0	10	**25**	**0.8**
May	27	4	1	13	**45**	**1.5**
June	23	7	0	11	**41**	**1.4**

Key:
Y on Y Aslt = Youth on youth assaults; Y on S Aslt = Youth on staff assaults
CHAB/Nglct = Child Abuse and Neglect investigations; UOF = Use of force



Assaults and Aggressive Incidents:

On 4/10/06, a youth who was locked in his room in the infirmary was assaulted by a youth who was mopping the floor. The assailant unlocked the victim's door, entered and assaulted the victim (ICAU Number37984). As a result of a DJS/ICAU investigation, a staff person was found to be negligent in their duties.

- On 5/4/06, two youth were involved in a fight, which resulted in one youth receiving injuries to his jaw and face. According to the DJS/ICAU investigation, staff was negligent for not intervening in the fight or reporting the incident as required. The case was referred to CPS for investigation but the victim youth was 18 years old and CPS did not investigate (See ICAU Number 38675).

- On 6/30, a youth alleged he was sexually assaulted by other youth (ICAU Case Number 40193) and the incident is currently under investigation with DJS and MSP.

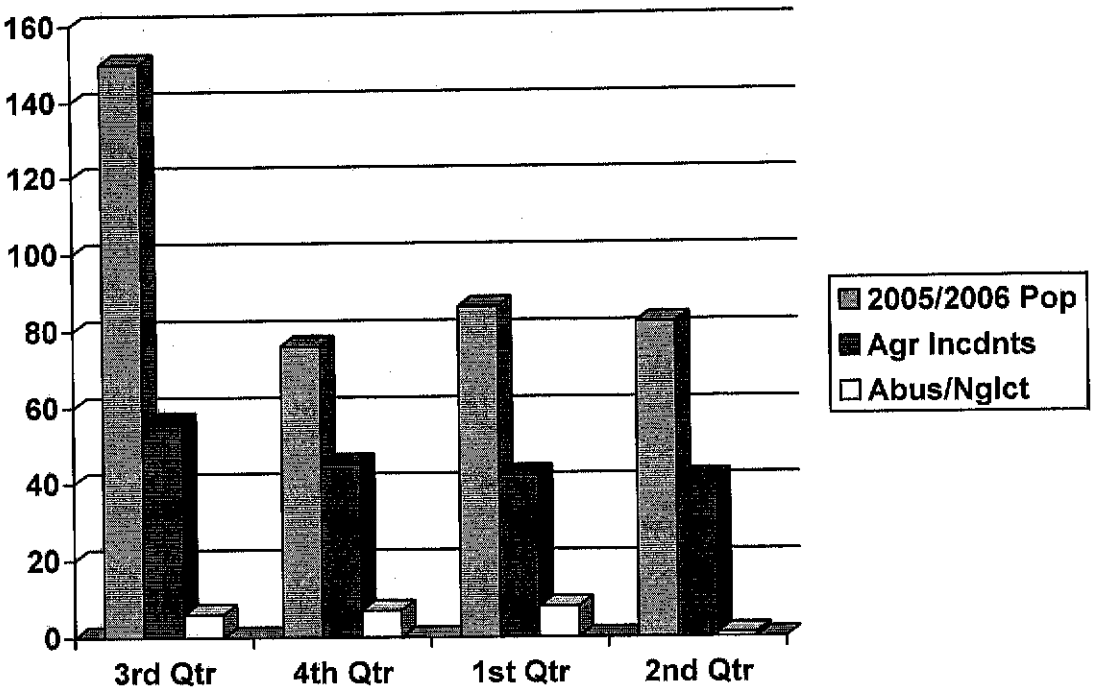
Child Abuse and Neglect Cases:
There was one (1) physical abuse accepted by DSS for investigation (ICAU Number 40183) which occurred on 6/24/06 but there are numerous problems with the report, witness statements and other documentation. DJS and CPS are investigating.

One other case of alleged physical abuse was referred to CPS but they declined to investigate (ICAU Number 38892). DJS conducted their own investigation of the incident and found it was not sustained.

There was one (1) neglect report referred to CPS this quarter but the victim youth was 18 years old and the incident was not accepted by CPS for investigation. However, DJS/ICAU conducted a thorough investigation and violations by staff were sustained (See above case ICAU #38675).

The following chart compares the number of aggressive incidents (Agr) per quarter from July of 2005 through June of 2006 with the average monthly population (Pop) during that

same time period. The number of child abuse/neglect reports (Abus/Nglct) investigated by CPS during the quarter are also recorded. The average monthly population declined from 86 last quarter to 82 this quarter



- Suicide Incidents:

Suicide behaviors, attempts, gestures and ideations have increased this quarter from last quarter. There were 4 last quarter and 13 this quarter. The following chart compares the number of suicidal incidents for the past 3 quarters with the population from the DJS Monthly Population Report.

- Exposed Rails on Bunk Beds (Suicide Hazard):

On 4/27/06, this monitor observed bunk beds with totally exposed rails on Roosevelt Hall in rooms 1 – 8, 11, 12 and 15.

Response:
All metal bunk beds have been replaced with fiberglass, suicide resistant beds.

- Fence Alarm Failure:

On 6/7/06, at 11:30 AM, this monitor discovered that several fence alarm sectors had not been working properly for at least four (4) days. Hickey administrators were not aware of the problem and the on-duty shift commander was also unaware of the situation. As of 6/21, all sections of the fence alarm were working properly.

Response:
The electronic fence alarm is only one aspect of the perimeter security for the facility. Visual checks are made constantly by the staff. In addition, repairs have been made to the system.

- Failure to Maintain Video Monitoring Equipment Outside the Infirmary:

On 5/18, this monitor observed that the video camera was recording activity outside the medical satellite building. This monitor inquired as to why the video was not able to record a recent alleged child abuse incident that occurred in the area and staff advised that there was a tape inside the recorder but no one knew how the system worked. Several staff and the Director of Security advised that they were not responsible for maintaining the video system and no one knew how it worked since the previous director of the medical section, since retired, had the unit installed. A working camera and recording system was available but there was no system in place to record, store and maintain the video tapes. The Assistant Secretary responded to the facility and was able to get the system to record. He advised a policy would be developed by the Facility Administrator to address the issue and the Director of Security would oversee the management of the system.

- Toothbrushes laying on Floor next to Beds:

On 4/27/06, this monitor observed the youths' toothbrushes and other hygiene products laying on the floor next to their beds, which appeared very unsanitary. Staff advised they have tried to have the youth place the items on their beds or use bags but neither option has worked.

Response:
We continue to encourage youth to use the appropriate holders for their toothbrushes.

- Broken Door Locks:

There were 4 rooms with broken locks but staff advised that youth do not stay in those rooms.

- **Vehicle Inspections:**

On 4/27/06 at 12:45 PM, this monitor observed an Industrial Supply truck enter through the sally port and continue behind the fence with no inspection to ensure there was no contraband or other equipment/personnel on board that might precipitate a breach of security or safety hazard.

Response:
We will take this under advisement. We have also advised Chesapeake Health Center to monitor incoming vehicles and since they are housed in a DJS facility, they are bound by the rules of the department and the facility.

Unabated for 30 or More Days:

- Pedestrian Sally port:

The outer gate of the pedestrian sally port was not working throughout the monitoring period.

Response:
All four gates have been replaced between August 04 and August 06.

EDUCATION:
Unabated for 30 or More Days:

- Staffing:

On 4/27, MSDE staff advised they were down 2 assistant teachers and 1 secretary

- Youth Planting Flowers and Bushes Improperly Supervised:

On 4/27/06, several youth were observed planting flowers and bushes outside the school. A teacher and a staff person were supervising the youth; however, one youth began lifting his shovel into the air and acted like it was a lacrosse stick. The staff did not address this dangerous action, the other youth began horse playing and it was several minutes before the group calmed down.

Response:
All youth are properly supervised and if not appropriate actions are taken with staff.

PROGRAMMING:

- Ford Hall (Orientation and Infirmary)

On 5/11/06, the Director of Security advised that the unit had 14 orientation rooms and 4 rooms for infirmary use. Intakes and assessments would be completed within 3 days and youth would be sent to a detention unit. There were no plans for separate mental health rooms.

- Replacement of gyms on units:

The gyms on each unit have been replaced with recreation rooms to provide a wider variety of activities for youth.

HEALTH/MEDICAL:

- Mental Health:

Mental health personnel from the private provider advised they were concerned that there were no separate beds for mental health youth. They recommended at least 10 separate beds on Ford
Hall that could be used specifically for youth with critical mental health problems.

Response:
This facility is a "detention" facility. Youth requiring inpatient mental health services will be referred to facilities that can best meet their needs. The facility is not designed to be a mental health treatment facility.

- Failure to Attach Body Sheet to Nurse's Injury Report:

A youth was injured in an assault and subsequent to a nurse's examination no body sheet was attached to the report to indicate where the injury occurred. (See ICAU Number 37984).

Response:
The Facility directive has been redistributed to all nurses to ensure that all policies and procedures are adhered to at all times.

FACILITY MAINTENANCE:
Unabated for 30 or More Days:

- The outer pedestrian sally port gate was not functioning throughout the monitoring period.

- The security cross arm that controls traffic exiting the facility was not working properly and the south side of Clinton Hall was very overgrown with weeds, brush and thorns.

- On 5/11, this monitor observed large chunks of paint peeled off the toilet stalls on Clinton Hall.

Response:
Maintenance and repairs at an aging facility is an ongoing process. The facility is continually monitored for and assessed for necessary repairs. This process has been enhanced by the addition of a new maintenance person.

ADVOCACY, INVESTIGATIONS AND MONITORING:
Unabated for 30 or More Days:
- Grievance Summaries:

This monitor has not received any monthly grievance report summaries from November 2003 through February of 2006, pursuant to the Standard Operating Procedure developed between this office and DJS.

Response:
As previously reported, there are no monthly grievance summaries to submit.

Unabated for 30 or More Days:
- Inaccurate/Late Reporting:

On 4/10/06 an incident report was submitted in reference to a youth on youth assault but the report indicated there was no injury (See ICAU Number 37984). The youth had an injury under his eye and this monitor contacted ICAU to have the report label changed to minor injury. The report was changed; however, it was also noted that there was no body sheet attached to the nurse's report that indicated what part of the body was injured.

Several incidents occurred in the latter part of June that were not reported by Hickey staff until July 6 (ICAU Numbers 40162, 40177, 40183, 40187, 40193 and 40194) and subsequently entered by ICAU personnel after that date. This late reporting made it difficult for this monitor to keep information on data and statistics current, but this report was updated as soon as the information became available.

ICAU Number 39517 was labeled as "Other" in the incident report database; however, there were allegations of illegal substance abuse and sexual child abuse

Response:
Training on report writing is mandatory for all staff. Four hours is required and is being conducted by DJS educational staff.

- Monitoring:

On June 28, 2006, it was reportedly announced at a DJS Superintendent's meeting that the Department was initiating a new policy with regard to the Office of the Attorney General Juvenile Justice Monitoring Unit. The new policy requires that the supervisor on duty at any DJS facility escort the monitor on his or her visit through the facility. Further it was stated that the monitor was not to interview a staff member without the supervisor present, and that youth were to be interviewed with the supervisor nearby. This policy compromises the ability of the monitor to gather crucial information that may lead to the discovery of concerns that affect the safety and security of youth. It is the expression of staff interviewed, including supervisory staff members that the perception of this policy

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

Response:
Privacy will be afforded to Independent Monitors when interviewing youth at the facility. Management and/or supervisory staff will escort the monitor throughout the facility to identify staff to the independent monitor and to address any issues, concerns or questions that the monitor may have during his visit to the facility.

The **MARYLAND YOUTH RESIDENCE CENTER (MYRC)** is a shelter care facility for up to thirty boys, ages 12 to 18 but its residential population has decreased due to the Choice Program that uses the facility to commit youth for 7 days only then works with them on Home Detention. Under the *Shelter Care Program,* boys who need supervision but are *not deemed dangerous* are housed there while they await a court hearing or placement in another residence.

STAFFING:
Unabated for 30 or More Days:
Population/ Choice Program:
In April, there were 23 youth in the facility and 1 was in the Choice Program. On May 11, there were 22 youth in the facility and staff said there were 6 youth in the Choice Program but a visit on May 18 revealed there were only 13 youth in the facility and no youth were in the Choice program. On June 7, there were 2 youth in the Choice Program.

Staff:Youth Ratios:
Due to staffing shortages, there is normally one direct care staff working on each unit but administrators state they are still trying to have 2 staff on each unit.

Staff Meetings:
Administration and staff have been meeting daily to address concerns.

SAFETY AND SECURITY
Aggressive Incidents:
The total number of aggressive incidents increased from 9 last quarter to 20 this quarter. Youth on youth assaults increased from 5 to 17 while use of force incidents remained the same from last quarter to this quarter at 3.

Unabated for 30 or More Days:
AWOLs and Facility Designation:
The Incident Report database AWOL incidents are still being designated as an "Escape from a Staff Secure Facility." During this past quarter, 14 incidents of youth running away from the facility were reported to the DJS Incident Report database. Of those, 12 were labeled "Escape" and 2 were labeled "AWOL." The facility is designated as a "shelter," youth are considered AWOLs and incidents should not be labeled as escapes.

Response:
Staff are being monitored and all incidents are being reviewed before being sent out

EDUCATION
MSDE is providing education at the facility. There are no significant concerns.

PROGRAMMING
After-school and Weekend Programming:
Youth who were interviewed advised that after hours activities have been sufficient. 11 youth were recently provided skybox seats to a Baltimore Orioles baseball game and youth have been swimming at the local YMCA.

Unabated for 30 or More Days:
Choice Program:
The facility has been be partnering with Choice in Baltimore County and Baltimore City to provide additional programming for younger youth. The Choice program is a 7-day transitional program to help youth transition into placements. Youth involved in the Choice Program have a very structured and comprehensive program each day. This monitor received a copy of the program schedule for the Choice youth.

Twelve youth are supposed to be in the program at any one time but participation continues to be slight except for the week of 5/11 when there were 6 youth in the program. In April, there were 23 youth in the facility and 1 was in the Choice Program. On May 11, there were 22 youth in the facility and staff said there were 6 youth in the Choice Program but a visit on May 18 revealed there were only 13 youth in the facility and no youth were in the Choice program. On June 7, there were 2 youth in the Choice Program. This monitor spoke with an administrator from the Choice Program in reference to the low number of youth participating in Choice and he advised that the numbers would increase now that Baltimore County youth are becoming involved in the program.

Recreation:
Some youth reported that they did not receive any outside recreation for their first 7 days at the facility. However, they state they did play ping-pong inside.

Response:
This is an inaccurate statement. Youth do not have to wait seven days to go outside.

HEALTH/MEDICAL
Child Abuse Reporting:
There were concerns that the nursing staff was not clear about reporting a suspected child abuse allegation. On 5/11, this monitor reviewed an incident of alleged abuse that was properly documented and reported by staff (Incident Report Number 38540); however, a subsequent incident was reported wherein a staff person had advised medical that a youth reported he was physically abused and the exam revealed a bruise on the youth's chest (Incident Report Number 39834). The medical staff consulted with this monitor to determine who should make the report to CPS and it was explained that "any staff who suspects abuse should make the report." There should be no ambiguity concerning child abuse reporting procedures.

FACILITY MAINTENANCE
The exterior of the facility was in acceptable condition. Repairs to the second floor bathroom are still pending DGS approval.

Evacuation Plan:
The facility maintenance engineer revised the evacuation plans for each floor of the facility and provided very detailed diagrams to indicate evacuation routes.

CHILD ADVOCACY, INVESTIGATIONS AND MONITORING
Grievance Procedures:
This monitor has received no monthly summary reports of grievances from DJS.

Response:
As stated previously, there are **no monthly** grievance summaries.

The **THOMAS O'FARRELL YOUTH CENTER (TOYC)** is an unlocked, staff-secure, privately managed residential program for male youth who are committed to the Maryland Department of Juvenile Services. The facility also maintains an off-grounds transitional living continuum (TLC), which is designed to provide a safe, secure environment for youth to support a successful transition from residential treatment back to the community. The TLC program will reportedly cease and the building will be vacated on July 1, 2006.

STAFFING:
Unabated for 30 or More Days:

- Staff Shortages:

On 5/4/06, the administration reported they were down 1 kitchen supervisor, 1 clinical director and 3 direct care staff.

- Staff:Youth Ratios:

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

- Youth Interviews about Staff:

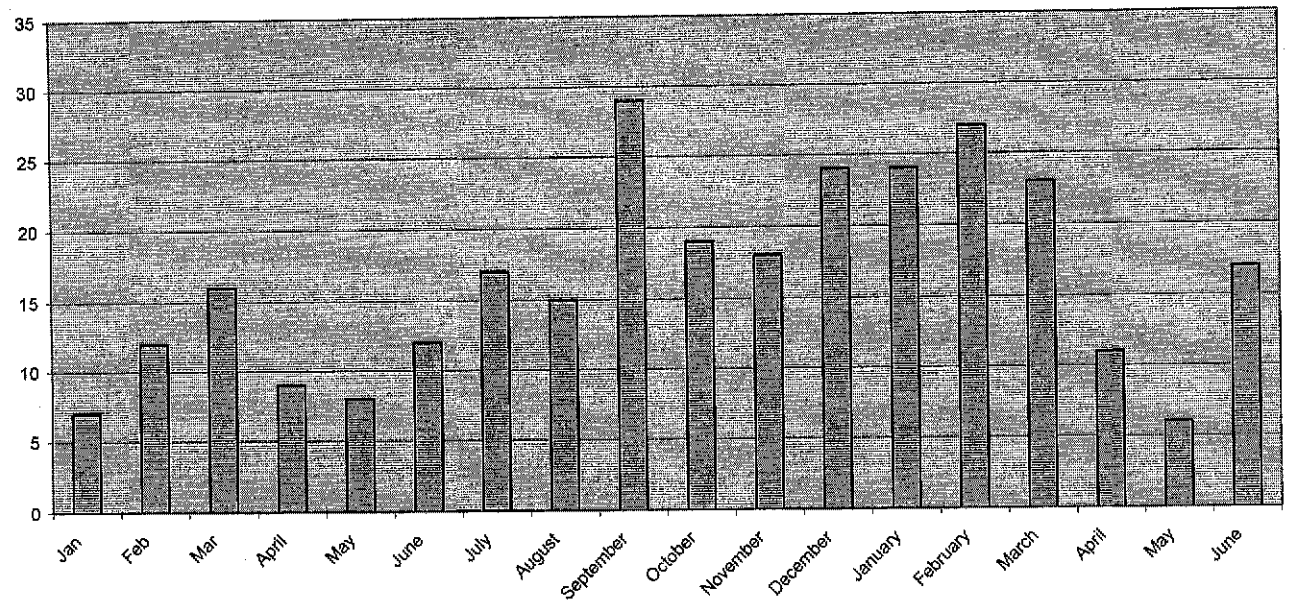
Several youth reported that some staff do not seem to care about the youth and some staff actually try to incite the youth to have them restrained. They would not identify any particular incidents but several staff names were provided in confidence.

SAFETY AND SECURITY

- Aggressive Incidents:

It appears that the trend for aggressiveness and violence has decreased at the facility. Incidents of youth on youth assaults decreased from 37 incidents last quarter to 18 incidents this quarter. Use of force incidents also declined from 36 last quarter to 14 this quarter.

See the following chart based on DJS Incident Report Database information.



- Escape:

A youth escaped from the facility on 3/11/06 and an investigation by DJS resulted in staff being charged with violating performance of duty procedures; however, the staff person subsequently resigned his position. This incident was not reported in last quarter's report and the case was closed on 3/29/06.

EDUCATION:

- Life Skills

Youth reported that they no longer had an instructor for life skills counseling.

Response:

We continue to recruit and fill vacant positions as they occur.

PROGRAMMING:

- Recreation

The Director of Recreation said the youth were playing various sports such as softball and he wants to start more adventure-based programming once MSDE finishes their audit of the facility. Youth advised they do not participate in recreation on the weekends and they sometimes just walk in circles around the gym to get exercise.

- Transitional Living Continuum:

On 4/25/06, this monitor observed the Transitional Living Continuum and found that only 1 youth was working at a local restaurant. On 5/4, staff and youth reported there were 2 youths working, 2 youths applying for jobs, 1 youth just received his GED and 3 others were trying to get their GEDs. Staff advised the TLC was closing in July.

HEALTH/MEDICAL:

- Health Department Inspection:

On 5/4, this monitor observed employees of the Helath Department conducting an inspection of the facility. Once the inspection was completed they provided this monitor with a copy of the report of violations. There were 72 violations at the

facility such as leaking sinks, bathrooms with no toilet paper, beds with torn mattresses, damaged ceiling tiles, dirty rooms and more serious violations such as:

- A maintenance closet was found unsecured
- There were unlabeled bottles of cleaner left out in the dorm

FACILITY MAINTENANCE:

- Transitional Living Continuum:

On 4/25, the grass needed mowing, the driveway had deep ruts that need repair, and the outbuilding continues to require demolition or serious repair. This monitor learned that the facility is planning on closing the TLC soon.

Unabated for 30 or More Days:

- Facility:

The rear of the facility is still in need of upkeep. On 5/4, the grass was very high and needed mowing. Leaves and trash are gathered in corners and along the walls. The decking area behind the kitchen is warped and dangerous to walk on. On 5/17/06, the laundry room drain on the east side dorm was stopped up, the door to the bathroom hits into the toilet when the door is opened, there was toilet tissue and water on the bathroom floor and the molding around the bottom of the walls needed replacement. The floor was wet and slippery. On 6/6 the grass needed mowing, several porch support posts were disconnected from their bases, there were large holes in the driveway area behind the dorms, there were loose building materials and other debris laying around, and a window was broken out of one of the rear doors from the dorms. On 5/17, this monitor took photos of the condition of the facility and the photos were included in the Timely Report.

ADVOCACY, INVESTIGATIONS AND MONITORING:

Unabated for 30 or More Days:

- Advocate Visits:

One youth advised he only saw the DJS Child Advocate one time about 1 month ago. Another said he had not seen the child advocate for 6 months. Several youth said they knew how the grievance procedure was supposed to work but they did not feel it was useful. The TOYC Admission Packet appears to have inadequate information concerning the DJS Grievance Procedure. On 5/5, this monitor contacted OPRA/ICAU to discuss the TOYC grievance process and their admission packet but there has been no reply to the request.

Response:

DJS has assigned an advocate to the facility.

Unabated for 30 or More Days:

- Grievance Summaries:

This monitor has not received any monthly grievance summary reports from November of 2002 through Feb. of 2006 pursuant to the Standard Operating Procedure developed between this office and DJS.

Response:

As previously stated, there are no monthly grievance summary reports to submit.

Unabated for 30 or More Days:

- Memorandum of Understanding:

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

Response:
The MOU continues to be a work in progress. It is currently being reviewed for signatures.

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

STAFFING:

- Population:

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

- Staffing:

Staff to youth ratios were found to be acceptable throughout the reporting quarter.

SAFETY AND SECURITY

- There were no significant concerns involving safety and security. There were 2 reported incidents of AWOLs last quarter and 3 this quarter. There was 1 youth on youth assault with no injury incident reported for the quarter.
- Interviews with youth indicate they feel safe and secure at the facility.

EDUCATION:
The education provided by this facility continues to be very focused and comprehensive to meet the needs of the youth.

PROGRAMMING:
The facility continues to provide outstanding programming services.

- A citizen volunteer was providing basic Karate instruction so the female youth could learn self-defense and build esteem.
- Church volunteers continue to visit the facility on Sundays.
- The youth still travel to the local YMCA for swimming and recreation several days each week.
- Youth continue to take supervised nature walks in a nearby park, and play basketball or other games on a daily basis.

HEALTH/MEDICAL:
No current concerns in this area.

FACILITY MAINTENANCE:
Unabated for 30 or More Days:
The interior and exterior of the facility were maintained properly; however, the driveway area still has some large holes near the basketball playing area and is in need of repair.

ADVOCACY, INVESTIGATIONS AND MONITORING:
Unabated for 30 or More Days:

- Youth report that they file their grievances directly with the facility administration and were not aware of the DJS grievance person or the DJS procedure.

Unabated for 30 or More Days:

- Grievance Summaries:

This monitor still has not received any monthly grievance reports pursuant to the Standard Operating Procedure developed between this office and DJS.

Response:
As previously stated, there are not monthly grievance summary reports.

Unabated for 30 or More Days:

- Reporting and Investigations:

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

Response:
This continues to be a work in progress.

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

STAFFING:
ACGGH maintains a minimum of two staff on duty at all times, including overnight. A weekend "floater" staff person is also present to provide additional security and programming options. Director Cindy McGill often works so that she is present not only during the day but also during some evenings and on some weekends as well. Weekly staff meetings are held to provide training and to discuss concerns. An evening cook position reportedly may be added. Staff training has been a priority during this reporting period. Mandatory training has taken place, and training records were well organized and readily available for review by this monitor.

SAFETY AND SECURITY:
There was concern that youth might have access to caustic cleaning supplies. Those cleaning supplies are now being stored in the garage. The inside door to the garage, however, is not as secure as needed. The locks could be removed or compromised with minimum tools.

- The door from the basement to the garage should be better secured.

Response:
The locks have been secured to ensure that youth do not have access to the cleaning supplies.

EDUCATION:
Most of the youth attend public schools in the area. Others work on preparing for the GED exam. Diane Markwood, the Educational Coordinator for the Allegany County Girls Group Home, has made frequent visits to the schools to help support the girls' academic success.

PROGRAMMING:
The residents at ACGGH receive formal individualized counseling sessions. In addition, group sessions are held with the residents whenever needed to resolve conflicts. Psychologist Dr. James Miller visits the group home two days per week (Mondays and Thursdays) to review the treatment needs of each youth, and to provide training to the staff on pertinent issues, such as group dynamics. The dynamics of the group at any given time is a key factor in the overall functioning of the program.

Allegany County Girls Group Home utilizes a level system. Points are awarded on a daily basis for appropriate behavior in a number of areas. As the youth gain points they are eligible to advanced to the next level of privilege and responsibility. Home passes can be earned by the residents to spend time with family members. Typical length of stay is about nine months unless longer treatment in the residential facility is indicated.

The schedule is full for the youth during the school year. During the summer some of the girls will have jobs. Volunteer projects will also be undertaken. The Lions Club has indicated that they will make a donation to the group home in exchange for some volunteer work at the Club's barbeque benefits. The residents also enjoy volunteering at Rocky Gap Resort in exchange for being able to use the facilities, lake and grounds.

HEALTH AND MEDICAL:
Health and medical needs are met by community resources, and reportedly are adequately meeting the needs of youth.

FACILITY AND MAINTENANCE:
Overall, the house is in good condition, and is well maintained by the cooperation of the Department and the YMCA. Upon visitation it was discovered that the dorm floor has some give in between the joists. Also, the stairs feel somewhat spongy. As noted above, the door leading to the garage from the basement is not secure. The garage is used for storage of cleaning materials, paint, and other substances that could be harmful to youth. Also, old files are kept in some unlocked file cabinets in the garage. The dressers used by the youth are in very poor condition. There is a lack of closet space in the upstairs dorm area. The lounge furniture in the den is badly worn. It is reported that the furniture upgrades will be attended to in increments as cost for total replacement is too high to be assumed in one installment.

The driveway has finally been slated for repair, and reportedly, sufficient funding has been provided to complete the project. Unfortunately, the cost is now about three times the original estimate given when first requested in the Spring of 2003.

ACGGH has not had regular Advisory Board meetings.

Response:
The plan is to have regular meetings.

- The dorm floor and stairs should be checked by a contractor for safety.

- Files cabinets should be secured.

Response:
An assessment and estimate of the deficiencies have been reported to the Director of Capital Planning for DJS.

- **Unabated for 30 Days or More:** Advisory board meetings should be scheduled regularly. An active advisory board could be helpful to the facility.

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

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

STAFFING:
A number of Youth Center direct care staff members have been temporarily detailed to the Western Maryland Children's Center.

Response:
Youth Centers staff has begun to transition back to their original assigned post at the Youth Centers. On September 13, 2006 all the Youth Center staff should be returned.

- **Unabated for 30 Days or More:** The staffing shortage was already affecting overall programming at the Youth Centers before the special assignments first to Noyes, and then to the Western Maryland Children's Center began. The issue of staffing shortage was first noted in the October-December Quarterly Report of 2003. During this reporting period two staff from each Center have been sent to WMCC during the week days. In addition to the special assignments, vacations, training, sickness, call outs, and family medical leave contribute to the shortage problem.

The Youth Centers are "staff secure" programs, but, sometimes on second shift and on weekends, there are only 4 direct care staff members in coverage for 36 to 40 youth. Due to the lack of Residential Assistants, Case Managers are regularly scheduled to be in direct care coverage. While Case Managers are also in direct care positions, excessive time in coverage without assistance makes it difficult for them to complete reports and/or spend individualized treatment time with residents. Some Youth Center administrators go

the extra mile in helping out in direct care coverage to help ensure security, and also so that youth can participate in off campus activities. Staff members express appreciation for this leadership by example.

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

- Even after a new staff candidate is interviewed and selected, it typically takes the Department four to six months to complete the hiring process. At times fingerprints are lost or smudged, and drug tests are also lost at DJS Headquarters, and have to be repeated. Many candidates simply cannot wait this long for employment, and look elsewhere. Many other candidates are unnecessarily ruled out because of failing the "mental health" test where for example, former soldiers in Iraq are ruled out because of the questions related to thoughts of killing.

- Because of the various reasons that a staff person may not be at work, each Center actually needs two staff persons for each position in order to maintain adequate coverage. Long term staff members have accrued lengthy vacation time. With family medical leave, staff members can be away from work for long periods of time. Combine these issues with the 40 hours of required annual training for staff, and callouts when staff members are sick or injured, and the result is that the old figure of 1.7 staff needed for each position is out of date with the reality of the situation. While it is good that staff have increased benefits, staffing shortage is very problematic for the safety, security and treatment of youth, especially with the more difficult and hardened youth being admitted. Two staff for each position are needed to maintain appropriate staffing levels.

SAFETY AND SECURITY:
The lack of adequate staffing noted above is a critical safety and security concern.

- **Unabated for 30 Days or More:** The youth being admitted into the Centers often have histories of violence, frequently exceeding the criteria by which the youth are to be screened for enrollment. Many youth have some level of gang involvement. On June 26, at 9:30 pm, a gang related fight broke out in the dormitory at Backbone Mountain Youth Center. The incident quickly turned into a group disturbance when numerous youth became involved. Reportedly, the situation nearly became a riot. The five staff members that were on duty are to be commended for their crisis intervention efforts, however, the situation was very dangerous and could easily have ended with someone being seriously hurt.

The graph below is an indication of the increase in the seriousness of convictions that often characterize enrolled youth. The graph is certainly only a partial representation as many charges are pled down to lesser convictions. The only conviction for many youth is Violation of Probation (VOP) with no indication of the prior convictions or behaviors. In May, 15 youth had 2nd degree assault convictions listed and 40 youth are listed as VOP.

	Feb. 05	March 05	May 05	July 05	Aug. 05	Sept. 05	Oct. 05	Dec.05	Feb. 06	April 06	May 06
Robbery	3	5	5	9	11	9	10	16	15	13	16
Burglary	8	9	10	12	12	12	12	12	10	11	9
1st degree Assault	1	1	2	2	2	2	3	3	5	5	5
Hand Gun Violation	0	0	0	0	0	0	2	2	3	2	1

Some youth that are turned down initially because of a concern that they may present a danger to others, or have needs beyond the Youth Centers ability to provide, are accepted nevertheless. These youth are reportedly accepted on a provisional basis and moved if behavior deems that removal from the Youth Centers is indicated. Removal has generally been accommodated when requested. At a recent Youth Center Advisory Board meeting a DJS Headquarter official indicated that if the Youth Centers did not take youth with the histories noted above, there would be no need for the Centers because youth with lesser offences that might previously have been sent to the Youth Centers are now being sent home by the judges on electronic monitoring and/or to receive community based services.

Response:
Youth with gang involvement are included in those admitted to the Youth Centers. It would not be responsible to not treat these youth. The Youth Centers continue to aggressively adjust and alter to meet the address these youth's needs.

The intake officer continues to diligently screen all youth. Periodically youth may be accepted on a provisional base. Historically some of the youth do very well. Other youth who have not have been quickly returned to detention for an alternative placement

The intake officer is legally bound to consider the adjudicated offense.

- It has also been suggested that the Youth Centers should take more youth by adding other residents to each group. Additionally, it has been suggested that the Youth Centers should release youth earlier. Most youth simply are not ready to be released earlier with an expectation that they will be successful in the community. Many youth have a "honeymoon" period of two to six months before their underlying problems surface to be addressed. Without time and programming to facilitate a change in belief patterns and at least some healing of emotional trauma, youth often "behave" their way through the program without making the meaningful changes that will facilitate long term success.

Fortunately, the number of incidents is down somewhat during this reporting period. The number of incidents is still nine higher than last year for the same reporting period. The Youth Center staff members are to be commended for reporting incidents as required.

Incidents as reported in the DJD incident data base.

	April/June 05	Y on Y	Y on S	U of F	Injury	Del/Crim Act	Total
Green Ridge		1			1		2
Savage Mt.				2	2		4
Meadow Mt.				1	3		4
Backbone Mt.		1		4			5
	Total	2		7	6		**15**
	July/Sept. 05	Y on Y	Y on S	U of F	Injury	Del/Crim Act	Total
Green Ridge		1		3	1	1	6
Savage Mt.		2		1	1		4
Meadow Mt.		3		5			8
Backbone Mt.		3		3	1		7
	Total	9		12	3	1	**25**
	Oct./Dec. 05	Y on Y	Y on S	U of F	Injury	Del/Crim Act	Total
Green Ridge		4		2	4	1	11
Savage Mt.		2		2	1		5
Meadow Mt.				3	3	1	7
Backbone Mt.		1	2	5	3	1 (Escape)	12
	Total	7	2	12	11	3	**35**
	Jan./March 06	Y on Y	Y on S	U of F	Injury	Del/Crim Act	Total
Green Ridge		7		2	1	2 (1-Escape)	12
Savage Mt.		3		1			4
Meadow Mt.		8		1	3		12
Backbone Mt.		8	2	19	3	1 Escape	33
	Total	26	2	23	7	3	**61**
	April/June	Youth	Youth	Use of	Injury	Delinquent/Crim	

		on Youth	on Staff	Force		Act	
Green Ridge		4	1	2	2		9
Savage Mt.		2	2	1	0		5
Meadow Mt.		5	0	0	2	1	8
Backbone Mt.		5	0	3	4	Group Disturbance 1	12
							34

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

EDUCATION:

The Youth Centers continue to accept youth that have been turned down by specialized schools. Youth in the categories necessitating 10-19 hours and 20 + hours are often in those categories because of behavior, but all categories display various learning disabilities or other learning challenges. Now the Centers have youth whose Individual Educational Plans require 30 + hours of special education. These hours often require individualized counseling by a school psychologist because of emotional disturbance. The youth in the 10-19, 20 +, and 30 + categories often need more intensive supervision and structure than other youth. The Youth Centers only has one School Psychologist to provide the review of referrals, numerous assessments of enrolled youth, and individual counseling where indicated.

The information in the graph below is taken from the Youth Centers Special Education Monthly Report.

Hours of Serv./Wk	0-4 Hours	5-9 Hours	10-19 Hours	20 + Hours	30 + Hours
May 1-31, 2003	8	6	13	4	0
May 1-28, 2004	8	7	13	6	0
April 1-29,2005	10	5	9	7	0
May 1-31, 2005	11	4	12	10	0
June 1-24, 2005	9	3	15	11	0
July 1-29, 2005	8	2	14	12	0
Aug. 1-31, 2005	6	2	15	15	0
Dec. 1-30, 2005	7	5	12	25	0
Jan. 1-31, 2006	8	7	9	25	0
Feb. 1-28	6	7	9	23	0
Mar. 1-31	8	9	15	14	0
April 1-30	12	9	14	7	7
May 1-31	11	8	12	11	9
June 1-30	11	9	13	13	5

- **Unabated fro 30 Days or More:** It continues to be unclear as to what set of regulations apply to the Youth Centers Educational Program. This issue was first noted in the October-December Quarterly Report of 2003. The Centers appear to function like a Public Alternative Education Program, but are different as well. MSDE has not promulgated regulation that applies directly to the Department of Juvenile Services Educational Programs. DJS responds that "the educational program at the Youth Centers is in accordance with the standards and under the supervision of Dr. Sherri Meisel, a noted professional in juvenile education" The response does not answer the questions or address the concerns.

Response:
Nationally and in Maryland, it is not uncommon that detained and committed youth have not been successful in their community school placements prior to their involvement with the juvenile courts, including "specialized" educational programs for youth with learning and/or behavioral difficulties. These prior school experiences do not indicate or predict that these students cannot be successful in the educational program at the YC, which is specifically designed to serve students with academic and behavioral needs.

The school psychologist is not the only provider of counseling services at the YC. Students with an IEP that includes counseling as a related special education service receive those services by the YC school psychologist when indicated, or by mental health providers through an inter-governmental agreement with Allegheny County Health Department. It is important to emphasize that all students receive the counseling services specified by their IEPs. In collaboration with the YC Special Education Coordinator and Principal, the DJ Superintendent of Education monitors caseload assignments and will recommend adjustments to staffing levels as warranted. To illustrate, two additional education positions have recently been allocated to the YC to support the academic and new college programs.

The confusion is problematic in that it is unclear what calendar schedule the Educators at the Centers should follow. The Youth Centers enroll youth throughout the year. Many, if not most of the youth are behind in their educational work, and in need of remediation, and/or special education services. Clearly more youth are being enrolled that require specialized services and increased hours of service. Though the Youth Center schools had a long standing record of effectiveness and close working relationship with the treatment staff, in the spring of 2003 the school schedule was changed at the Youth Centers. This was done presumptuously without reference to any regulatory authority or guiding standard. Previously the teachers working in the year around treatment program at the Youth Centers had the same time off allotment as other employees in the Centers. The teachers were, and are compensated for working in a twelve month program. School was open for youth on all days except state holidays and weekends. Additionally one day each month was dedicated to a teacher's meeting. School was open for approximately 237 days a year. The new calendar provides for 220 days of instruction. Youth that are typically in the Centers for an average of six months have lost at least a week or more of instruction during their placement. The educators have been taking off a total of 4 weeks of "professional days" throughout the year in addition to holidays and vacation days. These professional days are typically coupled with holidays, and result in week long periods when there is no schooling. The absence of teaching staff along with the extended educational holidays is particularly problematic due to the overall direct care staffing shortage. This is most difficult for the youth and the direct care staff near the Christmas holidays. Teachers are scheduled to be off for nine days this year in the

Centers. Tensions are heightened during this time, and the youth need as much supervision and productive activity as can be provided by the entire Youth Center staff team. It is very important that the educational staff and treatment staff work as an integrated whole in the Centers, recognizing that the treatment and education of youth with emotional, behavioral, and learning problems is mutually facilitated.

Most youth interviewed identify school as being of value to them during their placement at the Youth Centers, and many teachers go the extra mile in helping youth. At the Meadow Mountain Youth Center the youth consistently comment that they usually just work in their folders and receive little individualized instruction. Youth report that the aquaculture program at Meadow Mountain is very much valued, and several off campus activities have been undertaken in conjunction with the program.

PROGRAMMING:
Programming has been affected by several factors. Basic supervision has to take priority due to the more challenged and challenging youth being admitted. Lack of staffing is the most crucial factor that affects programming capability. Staff members simply cannot devote the individualized time needed when alone in coverage. One or two youth often require much of the staff member's time and as a result the less demanding youth often do not receive the treatment attention needed. As noted, the Youth Centers are "staff secure" programs, with no fences to contain youth, and no continuum of care capability. The lack of continuum limits resources available to provide treatment from more restrictive to less restrictive environments depending on the need of the youth.

- **Unabated for 30 Days or More:** The transportation policy requires two vans and four staff to take a group off grounds. With the limited staffing and the limited number of vans, these off grounds trips often cannot take place. This concern was first noted in the July-September Quarterly Report of 2005.

In spite of the obstacles noted above however, the Youth Center staff members do much to continue creative recreational and experiential treatment/educational programming, both on and off grounds.

- **Unabated for 30 Days or More:** A very important aspect of the Youth Center treatment program is recreation. Funding for recreation has been very limited since the revision in the contract with AT&T. There is now a line item in the budget for recreation, and this is a beginning. Adequate funding of recreation/treatment is very important to the overall programming capability of the Youth Centers and is a vital aspect of youth's treatment and recovery. This issue was first noted in the Quarterly Report of January-March 2005.

Response:
Recreation funding was included as an item in most recent future budget planning.
Once the item is in the budget it will be more likely that increases can be realized.
The Youth Centers support the need for recreational funding and acknowledge the importance of recreation as part of the treatment process.
It should be noted that the Youth Centers continue to provide outstanding recreation activities for the youth through creative and alternative routes.

- **Unabated for 30 Days or More:** The Ropes/Reflections Program which is located on the Meadow Mountain campus is another potentially very valuable treatment tool. The

Program was staffed by two full-time personnel at one time, but one of the positions was moved to direct care. The remaining Ropes/Reflections staff member finally quit after repeatedly being in coverage because of the staffing crisis, and not able to provide the experiential programming for which he was trained. As a result, services provided to the youth have been curtailed entirely. If fully staffed, the Ropes/Reflections program would have the capability of providing valuable experiential services to Youth Center youth, and also serve many other youth as an early intervention and prevention experience. Staff members from the other Youth Centers, who are trained and qualified or certified, have assisted with their groups in the Ropes program when they are available. Certifications have to be renewed, and at this time, in addition to the Ropes/Reflections Program, the tower at Backbone Mountain and the other experiential elements at Savage Mountain are not being utilized for the youth. This concern was first noted in the July-September Quarterly Report of 2005.

Family involvement is encouraged at each Youth Center. Green Ridge Youth Center has begun implementing home visits for Area III youth placed in the 9 month Therapeutic Group program. When a youth nears the end of his treatment, and has earned a home visit by successfully completing treatment goals, he initially goes on a short home visit, and if successful, may go on a longer home visit. This programming has been positive overall. Youth who were interviewed expressed a lot of enthusiasm for the family visitation and perceived it as a valuable incentive to complete the program successfully.

The other Centers have not implemented home visits as of yet, but the possibility is being considered upon evaluation and outcomes of the Green Ridge visitation policy. The youth at all of the Centers do make calls, and families may visit the Center.

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

HEALTH/MEDICAL:

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

FACILITY MAINTENANCE:

- **Unabated for 30 Days or More:** The National Safety Board has found all 15 passenger vans to be unsafe. Each Center used to have 4 vans, most of which were 15 passenger but they lost a number of vans to other DJS facilities by request of DJS Headquarters. All of the replacement vans will be twelve passenger vans. Each Center is in need of 4 vans in order to accommodate the various programmatic needs, and in order to have emergency transportation if required. This concern was first noted in the July-September Quarterly Report of 2005. The Transportation office located at Green Ridge Youth Center is also in need of additional new vans.

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

Response:
The Centers have just been informed that they will be receiving 6 new 12 passenger vans and 1 new pick up truck.

Additional replacements are scheduled and the department will determine the number and need for vans.

The number of persons in the van has been reduced procedurally to address the Safety concern.

The Youth Centers have an excellent Emergency Response Plan for evacuation which has been drilled and exercised.

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

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

Response:
Same as for all DJS Facilities

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

STANDARDS:
- **Unabated for 30 Days or More:** Commitment Care Standards are not provided for DJS commitment care programs as of yet. This unit was originally included in beginning stages of development of Commitment Care Standards as the Department clearly recognized the lack and the need. Subsequently, it was reported that standards were being developed and would be presented in March of 06. The Standards have not been developed as reported, nor has the Juvenile Justice Monitoring Unit been invited to participate in their development. DJS has responded to the inquiry as to the status of the standards that, "the Department will determine the need for Commitment Care Standards." Apparently the previous commitment to the development of the needed standards is in question, and without explanation as to the reasoning behind the

reluctance to produce standards for their committed programs. Youth Centers currently operate under a procedural manual and Secretary Directives. This concern was first noted in the April-June Quarterly Report of 2004.

DJS Detention Standard 3.1.2 Residential programs states that: "Any residential program utilized by the Department as a residential alternative to secure detention must be approved for use by the Department, must be licensed, and must conform to all requirements as articulated in COMAR 01.04.04.

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

STAFFING:
A new Administrator, Anthony Wynn, began his duties at Noyes on April 12th 2006. Mr. Wynn was an Assistant Administrator at a detention facility in New York State and has 15 years of combined experience in working in private and public facilities. Ms. Erica Crosby has been hired as the Assistant Superintendent. Before coming to Maryland, Ms. Crosby worked in Georgia for a number of years in both adult and juvenile detention. She began her duties at Noyes on June 14th.

Region III has been divided into two districts, the Central District comprising Montgomery, Howard, Frederick, and Carroll Counties, and the Western District comprising of Washington, Allegany, and Garrett Counties. Delmas Wood has been assigned to head the Central District, and as such, will oversee the operation of Noyes.

There has been, and continues to be considerable effort made to improve the staffing at Noyes. The Department has made salary adjustments to help attract and retain employees working in the facility as it is located in Montgomery County where the cost of living is higher then elsewhere. Also, the Department is attempting to facilitate the interviewing and processing of applicants in order to bring new employees into the facility more quickly.

- Historically it has taken from four to six months from interview to start date. Many job seekers simply cannot wait that long to find employment. Also, many potential employees have been ruled out after failing the "mental health" test where for example, former soldiers in Iraq are ruled out because of questions related to thoughts of killing.

- Another issue affecting employees is the number of PINs allocated to the facility. A PIN assignment gives the employee full benefits. Noyes reportedly has a lower percentage of PINs than other facilities, and this impacts hiring and retention. The overall allocation of Residential Advisor positions is low. The facility needs about 60 positions to provide consistent coverage. Staff training, which requires 40 hours a year, vacations, sickness/injury, family medical leave, and last minute call outs all contribute to diminish the number of staff on duty, and the need for forced overtime. In reality the facility needs a two to one staff/position ratio.

Though staff shortage and staff working excessive overtime are still major concerns at Noyes, double coverage of the units has improved. In January 2006 the units on first shift, from 7am to 3pm, were single staffed 48% of the time, and on second shift, from

3pm to 11pm, the units were single staffed 66% of the time. In March 2006 both shifts had units with single coverage only 23% of the time, and thus, had at least two staff on the unit 77% of the time. In a sample of 26 days taken in May and June the units had double coverage 81% of the time on first shift, and second shift had double coverage of units 73% of the time. While this is a significant improvement, it has to be noted that it is at the expense of staff working many hours of forced overtime. This often leads to staff exhaustion and burnout. It is reported by staff that it isn't uncommon to work 4 days straight 16 hours per day. One staff member said that in two weeks he had accrued 85 hours of overtime. Some staff members live up to an hour and a half away from Noyes. To work back to back 16 hour shifts means that at best they get 5 hours of sleep. Having tired, frustrated and/or burned out staff is dangerous for youth and for staff.

- **Unabated for 30 Days or More:** In addition to the need for experienced direct care personnel, Noyes is lacking many other staff. Two additional Residential Group Life Managers are needed.

- **Unabated for 30 Days or More:** There is only one full-time Case Manager. A minimum of three full-time Case Managers are needed. Reportedly a second Case Manager will be on board in July.

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

- **Unabated for 30 Days or More:** Though only one Addiction Counselor position is currently slated for the facility, three Addiction Counselors are needed to provide the services that the youth require. This is especially true when the facility is over populated.

- **Unabated for 30 Days or More:** A Social Worker is needed to assist Dr. Mason with the delivery of mental health services to youth as required. It is reported that a secretarial position is being sought to assist Dr. Mason.

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

Response:
Staff recruitment and retention is a priority at this facility. More position numbers have been requested. The hiring process is on-going.

A total of three case managers are assigned to the facility. Recruitment for this position is on-going. DJS will determine the need for additional case managers.

We will determine the need for an additional position and we will submit the paperwork for another Addiction Counselor as soon as we determine the need.

Anthony Wynn has been working to promote better communication, teamwork and professionalism at Noyes. This has been much needed, as at times, staff demeanor and attitude has been very problematic. Staff talking to each other and to youth in a demeaning and/or crude way has been tolerated at times in the past without correction. This is reportedly changing.

• **Unabated for 30 Days or More:** Some staff members have not been aware of some of the policies and procedures. Also, policy and procedure has been implemented inconsistently from staff to staff. Staff meetings are reportedly being held to promote teamwork, and to train in the appropriate and consistent implementation of the policies and procedures. It is reported that a comprehensive policy and procedural manual will be developed. This concern was first reported in the October-December 2005 Quarterly Report.

Some important supervision and training improvements have been made. When two staff are on a unit they are designated as "A" staff or "B" staff. Staff "A" is primarily responsible for security, and staff "B" is directed to focus on interaction with the youth. In conjunction with this staff assignment pattern, there has been more emphasis placed on developing a therapeutic/relational environment between staff and youth. Potential conflicts can be better observed by staff being in the midst of the youth rather than on the sidelines and early intervention tactics can be used to defuse the situation before it escalates. A training practice has also reportedly been implemented whereby incidents are reviewed with staff to determine how situations could have been diffused or handled in a better way. Additionally, when there is a crisis the staff members are using coded language on the radios so that the youth are not as easily made aware of the nature of the call.

SAFETY AND SECURITY:
Safety and security is affected by a number of factors. Staff shortages, staff inexperience, poor staff conduct, lack of programming, overpopulation, and facility inadequacies have all figured at times as a contributing factor to the breakdown of safety and security.

• Though the rated capacity at Noyes is 58, the population count on April 3rd it was 72. On June 20th the population was 76. Reportedly the population has reached as high as 80 during this quarter. Overpopulation creates a serious safety and security risk. Not only is the youth/staff ratio affected, but also because various rival gangs are typically represented in the population. Gang "flashing" of signs can and has frequently resulted in a fight breaking out.

Incidents continued to be a major concern in April and May, including an escape in each month. The escape of one youth in April occurred as a result of poor staff communication and staff error. The escape in May of three youth involved assistance, and was very troubling in that the fence was cut in broad daylight in front of staff by a youth and an adult outside the fence. Quick action and determination on the part of Mr. Wynn and other staff resulted in the capture of the three escapees.

The number of incidents in June declined considerably and presumably as a result of better staff communication, teamwork, and the implementation of early intervention tactics.

• **Unabated for 30 Days or More:** Safety and security at Noyes is severely hampered by the lack of fencing security, and lack of monitoring equipment both outside and inside the facility. The fence is obviously vulnerable to being cut from the outside. Sensors, lighting, cameras, monitors, and recording equipment is lacking and badly needed to enhance the outdoor security of the facility. It is also reported that youth who have been at Noyes, and/or others, have been coming up to the sleeping room windows at night and interacting with the youth inside the facility. The front door and windows are not tinted,

and there is no announce box at the entrance. The interior of Noyes is not equipped with cameras, monitors and recording equipment. This greatly affects the safety and security of youth and of staff. Though hand held video cameras are available to use, this is impractical, and inadequate to ensure the necessary protection and documentation. Fencing and monitoring concerns have been noted since the July-September 2005 Quarterly Report.

Incidents:

Month	Y on Y ASLT/Riot	Y on S ASLT	CHAB	UOF	TOTALS	Avg. # of Incidents Per Day
July 2005	9	1		6	16	0.51
August 2005	11	1	1	6	19	0.61
September 2005	18	1	2	4	25	0.83
Quarter Totals	**38**	3	3	16	**60**	**0.65**
October 2005	29	1	1	2	33	1.06
November 2005	14			3	17	0.57
December 2005	13	1	Delinquent/ Criminal Acts by youth - 4	4	22	0.70
Quarter Totals	**56**	2	5	9	**72**	**0.78**
			Child Abuse			
January 2006	12	2	2	2	18	0.58
February 2006	14	1	Possession of Contraband 1	5	21	0.75
March 28, 2006	15		4	4	23	0.74
Quarter Totals	**41**	3		11	**62**	**0.69**
April	16 + 1 Group Disturbance + 1 escape 18	3	Contraband 3 - Staff Child Abuse 1 - 4	12	37	1.23
May	20 + 1 Escape 1 21	1	Del/Crim act by youth 1- Staff Child Abuse 1- Suicide Ideation 1- 3	7	32	1.03
June	12	0	Contraband 1 - Suicide Ideation 3 - Suicide Attempt 1 - 5	3	20	.66
Quarter Totals	**51**	4	12	22	**89**	**.97**

EDUCATION:
The DJS Director of Education asserts that the Noyes educational program is comprehensive in nature in providing the curriculum and services that the youth require. Youth and staff members report however that little education takes place.

- **Unabated for 30 Days or More:** Concerns about education were first reported in the October-December 2005 Quarterly Report. The classes that this monitor has observed on the units have been very poorly implemented as the majority of youth are not engaged in the learning process. Youth complain that the curriculum repeats frequently and does not interest them or meet their academic level. Overcrowding, lack of direct care staffing, or staff that have worked back to back 16 hour days also contributes to a situation that is not conducive to creating a good learning atmosphere. Additionally, the lack of space to break the population into small classes greatly hampers education. The youth on the units at Noyes have widely differing educational abilities, from youth at the elementary level to youth that are capable of college level coursework. Others have various learning difficulties, and problematic educational histories. A number of youth stay well beyond 30 days, and some have stayed in detention at Noyes for a number of months. English is a second language to many Hispanic youth.

Noyes lost several teachers and was not fully staffed for a time during this period. One teacher left in disgust at the end of March, subsequently writing a letter to the Governor detailing his frustrating and fearful experience while trying to teach a class on one of the units at Noyes. The teacher was not exaggerating the situation as this monitor was present on the unit and observed some of the behaviors mentioned by the teacher. Subsequent interviews also indicated that the allegations made by the teacher were accurate.

The Educational Director at Noyes is working closely with Montgomery County Public Schools. It is reported that the Noyes teachers will be invited to attend Montgomery County teacher training and development sessions. Also, the Montgomery County Public School system has offered to allow Noyes to use their curriculum guides. This cooperation between the facility and the county will hopefully result in broadening the curriculum capability at Noyes and also facilitate credits being more readily accepted by receiving schools upon a youth's release from detention.

Interviewing and hiring to fill teacher vacancies is taking place. Teacher's salaries were recently increased significantly, and this should help with hiring. It is also reported that the school trailers will be renovated during the summer.

PROGRAMMING:
The new Director is working toward implementing more and better programming at Noyes.

- **Unabated for 30 Days or More:** During this quarter there continued to be excessive "down time" according to youth and staff. This concern was first noted in the July-September Quarterly Report of 2005. Youth, sometimes over 20 on a unit, were kept in the day room watching, television, playing cards or dominoes, sleeping, or acting out due to boredom, lack of structured activities, and lack of adequate supervision.

The problem is made worse, as mentioned above, by the presence of youth that are members of different gangs. Some of the incidents have been gang related. Movement of the units throughout the facility has also been problematic as units have contact with

one another where rival gang members flash gang signs and make threats. More emphasis is being placed on gang member identification and staff training in gang awareness.

The three-level program that assigns points and gives some added privileges as youth gain points is inadequate. It has been reported that a multi-level system similar to the one used at the Western Maryland Children's Center will be developed to meet the particular needs of the youth detained at Noyes This will be a very positive step in providing more adequate programming. Some cookouts on Wednesday afternoon, and other special activities have reportedly taken place.

- Recreational programming has been inconsistent. Youth and staff report that outdoor recreation has been infrequent, and that even basic indoor recreation does not always take place as required.

- **Unabated for 30 Days or More:** Concern about the pending population at Noyes has been consistently reported since the October-December 2002 Quarterly Report. The number of youth and the length of time that they await placement while in detention at Noyes continues to be of significant concern. On April 24th, 2006 the pending placement population at Noyes numbered 27 youth. Of the 27 youth in pending placement status 6 had lengths of stay in detention at Noyes that exceeded 30 days, 81, 70, 66, 50, 48, and 36 days. On June 15th, 19 youth were in pending placement and 7 youth had lengths of stay in detention at Noyes for over 30 days, 124, 104, 63, 51, and 49 days. These youth are entitled to individualized treatment services that are not being provided at Noyes. The number of youth in pending placement has decreased overall during this period.

HEALTH AND MEDICAL:
Noyes has four contractual nurses while other facilities have nurses with PIN positions which include benefits. In the past, because of understaffing at Noyes, the nurses report that they have had to escort youth to and from the units to the nurses station, and this puts themselves and therefore the youth as well, at risk. This is reportedly being corrected.

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

- Though the nursing staff assert that it is not so, youth do complain that sometimes they are not seen by the nurse or doctor within a reasonable time when they place a sick call. This writer will continue to monitor the concerns. Not only should standards be kept, but the attitude and atmosphere of care in the delivery of health and medical services is a crucial aspect of providing a therapeutic environment.

- **Unabated for 30 Days or More:** Food that is supposed to be served hot at Noyes is reported by staff and youth to often be cool upon delivery. The meals are prepared at RICA and transported to Noyes from that facility. Minimum temperatures are required by the Health Department. The new administration is reportedly looking into the problem. This concern was reported in the October-December 2005 Quarterly Report.

- In the early part of this quarter it was reported that supplies such as soap, lotion, shampoo, washcloths have been in short supply. At times staff members have had to go to a local store to buy the needed items. Youth also complained that their sheets were not

laundered as required. These concerns are reportedly being addressed by DJS, and the new leadership at Noyes.

Response:
A laundry schedule has been developed to ensure the cleanness of youth linen. Several orders have to be placed and filed to ensure the youth are receiving the proper hygienic items.

FACILITY AND MAINTENANCE:

- **Unabated for 30 Days or More:** The beds in the sleeping rooms provide tie off points that youth could, and have used in an attempted suicide. On June 28th a youth attempted suicide by tying a sheet around her neck and hanging from the bed. Fortunately the Case Manager entered the unit and discovered the youth before she could seriously harm herself. The concern regarding the beds at Noyes was noted in the October-December 2005 Quarterly Report.

Response:
The agency will continue to seek a bed that posses no danger to our youth.

- **Unabated for 30 Days or More:** The gym walls underneath the basketball goals used to have padding but only one pad is still on the wall. The padding is needed to help prevent injury to youth playing basketball. Reportedly, requests have been submitted for the padding. This concern was raised in the October-December 2005 Quarterly Report.

ADVOCACY, INVESTIGATION, AND MONITORING:
DJS asserts that grievance forms are always available and replaced on the units as soon as staff become aware that they are needed. At times youth have expressed that it doesn't help to write a grievance as they feel it doesn't make a difference. Some youth report that the Advocate is very helpful.

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

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

STAFFING:
It should be noted that the staff members at WMCC have worked hard to try to maintain the positive and proactive culture for which they have become known.

- **Unabated for 30 Days or More:** WMCC continues to face major staffing concerns. Staffing concerns have been consistently reported beginning in the Quarterly Report of October-December, 2004. Youth center staff members have been temporarily assigned to WMCC to fill in Mondays through Thursdays. This deployment of staff, while helping WMCC, has further compromised staffing in the Youth Centers. Additionally, Youth Center staff members have not been trained specifically for the detention environment at WMCC. This lack of facility specific training appeared to contribute to the escape. The overall lack of staffing at WMCC is made worse by the overpopulation of the facility.

Safety and security is further compromised by excessive staff overtime, staff fatigue, and burnout. Staff call outs, sickness/injury, losing staff positions to other DJS facilities, in addition to accommodating staff training requirements and staff vacations, has added to the staffing crisis. Infrequently, but at times, one staff member has been left alone with 16-17 youth for up to two hours due to a last minute staff call out. When this happens another staff member is called to replace the staff member that called out. Also, there is a roving staff member present in that facility, though that person may be busy with other duties.

Response:
The Department has been focusing much effort on recruiting, hiring and training.
The increased hiring has allowed a majority of the Youth Centers employees to return to the Youth Centers
Many additional candidates have been identified and should be starting soon. If this occurs as anticipated the staffing shortages will be resolved.

- **Unabated for 30 Days or More:** On the 6 bed pods there is only single staffing. Having only one staff on a locked unit is made even more hazardous by the presence of rival gang members in the facility and the additional necessity of separating co-conspirators. At times the six bed pods have had to accommodate up to nine youth with three youth sleeping out in the day room in the plastic boats. When there is an "all staff duress call" in which all staff are required to respond to an incident, it creates a security risk as there are three additional youth that cannot be secured, and/or protected.

Response:
Rarely, if ever, has a staff member been left alone with 16 – 17 youth.
Double staffing on Pods A and Pods B would result in a 3:1 ratio. This is unrealistic economically.

- Often other staff members such as cooks, maintenance staff, and teachers help out when they can in providing supervision or in the control room. The control room staff assumes a critical function, and in a crisis the functioning of that staff member could become pivotal in providing security. While control room training is provided, there is no check list of staff training or documentation that staff have mastered the many functions necessary for effective operation of the control room should a crisis erupt.

- **Unabated for 30 Days or More:** On the second shift from 3pm to 11pm, and on weekends, the situation is more crucial as there are no administrative staff members or teachers in the facility to help out as during the day. There is supposed to be a Resident Advisor Supervisor on duty along with a roving staff member on second shift. In addition to the Supervisor, two roving staff members are needed especially when the facility is overcrowded. Staff on second shift and on weekends must attend to many additional tasks in addition to providing basic supervision. Family visitation, youth intakes, medical calls, special treatment needs, doing the laundry, and filling out reports as required following an incident are examples of situations that require additional staff. The intake of a new youth requires that two staff be present. When only one or even two people are available to accommodate all of these needs safety can be compromised. If several situations or incidents occurred simultaneously, it could become overwhelming.

- **Unabated for 30 Days or More:** Other positions also need to be filled. Though WMCC was not originally allotted two Case Managers a second Case Manager was at

WMCC for some time as he had been hired for the Victor Cullen program. That program did not come to fruition. He eventually left WMCC because of having no benefits. Generally one Case Manager for 24 youth is sufficient. Having a second Case Manager at WMCC however, was extremely helpful. This position is especially needed as the population for this 24 bed facility has averaged about 30 youth, sometimes going as high as 35 youth. The remaining Case Manager is on maternity leave and the person that is temporarily filling in is frequently called into her primary role as direct care.

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

Response:
We will determine the need for a second position.

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

SAFETY AND SECURITY:
On June 28th a youth escaped from the outdoor recreation area by climbing over the fence. Subsequently the youth stole a car and led police on a high speed chase ultimately ending on a residential street in Cumberland.

- **Unabated for 30 Days or More:** The need for additional fencing to secure the outdoor recreation area has been cited numerous times since a previous attempted escape over the fence that occurred in September of 2004. The youth was successful in getting over the fence but was apprehended immediately afterwards.

Response:
Estimates have been submitted and a decision will be made relative to the additional fencing.

- **Unabated for 30 Days or More:** Safety and security is affected by staff shortage, staff fatigue, inexperienced new staff, and temporary staff that have not had facility specific training.

- **Unabated for 30 Days or More:** The population at WMCC has frequently numbered over 30 youth during this reporting period. The facility is required to take up to 10 youth over their rated capacity before the on call administrator is called to take even more youth. Additional youth sleep in day rooms in plastic mattress containers called "boats". Having youths over the rated capacity has made it more difficult to provide services and to maintain safety and security. When there is a crisis there is no place to separate, secure and protect the additional youth. The concern about over population has been consistently reported since the July-September 2005 Quarterly Report.

Incidents:
Incidents at WMCC have continued as the table below indicates.

Month/Yr	Y on Y	Y on S	D/C act	U of F	GP. Dist.	Total
1-04	2	1		2	1	6
2-04				7		7
3-04				6		6
4-04	1			4		5
5-04				9		9
6-04	2		1	7		10
7-04	1		1	4		6
8-04	1	1	1	7		10
9-04	2			4		6
10-04	2			4		6
11-04				5		5
12-04	2			3		5
Total	13	2	3	62	1	**81**
Month/Yr	Y on Y	Y on S	D/C act	U of F	GP. Dist.	Total
1-05	1			5		6
2-05				6		6
3-05	5	1		6		12
4-05	2			13		15
5-05	1			13		14
6-05				14		14
7-05	7		1	15		23
8-05	5	1		8		14
9-05	9			14		23
10-05	11	1		13		25
11-05	3			3		6
12-05	4			7		11
Total	48	3	1	117		**169**
Month/Yr	Y on Y	Y on S	D/C act	U of F	GP. Dist.	Total
1-06	6			6		12
2-06	7		1	6		14
3-06	3	1		7		11
4-06	4	0	1	12		17
5-06	4	2	0	7	Child Abuse by staff - 1	14
6-06	5	1	0	3	Escape - 1	10

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

- The total number of incidents more than doubled from 2004 to 2005, and the youth on youth assaults more than tripled during the year. After February of 2005 the population at WMCC began to be forced over its rated capacity of 24, and the incidents increased as shown. On numerous occasions WMCC has been forced to take "special assignment"

youth from other detention centers because of the youths' negative behavior. Safety and security is threatened especially with the staffing concerns noted above.

- WMCC has not instituted a process whereby incidents are reviewed and used as training instruments to help staff evaluate their performance and correct mistakes. Understaffing makes this important type of training more difficult to undertake.

- **Unabated for 30 Days or More:** As reported consistently even before installation, the presence of vitreous china toilets and sinks in the youths' sleeping rooms and bathrooms presents a danger to youth and staff. The Department states that "china toilets were made safe by removing the seats", and "since that time no toilets have been damaged". Not only do youth have to use the toilet without seats, but to assert that the toilets have been made safe and that no damage has occurred since removing the seats is not at all accurate. The material breaks into dangerous knife like shards. One youth at WMCC broke the toilet merely by kicking it. The same material has been used in the Lower Eastern Shore Children's Center, and youth have broken the toilets by kicking off the water feed pipe and hitting the toilet. This Office has recommended that stainless steel fixtures be installed. The Department agreed in **(January of 2004)** to a remediation plan that included: to replace the vitreous fixtures with stainless steel in no less than two bedrooms immediately; replace the vitreous fixtures with stainless steel upon any breakage or damage; and retrofit the remaining vitreous china fixtures with stainless steel within a three year period. This agreement has not been acted upon by the Department. This concern, as noted above, was first raised during construction of the facility in 2003, and cited in the Quarterly Report of July-September 2003 and in every Quarterly Report since that time.

Response:
Unfortunately, at this time there is some difficulty in matching the replacement fixtures to the existing plumbing.

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

PROGRAMMING:
The leadership staff members at WMCC have worked hard to develop a culture that values an attitude of respect for youth, and expectation of positive behavior on the part of youth. Most youth have responded in kind. Positive behaviors are rewarded and negative behaviors are confronted. Routine and order is generally maintained and this helps provide a sense of predictability and security.

- With being under staffed, overpopulated, and given special assignment youth, it has been much more challenging to maintain the level of intervention and programming that was previously the norm. At times the sense of safety has been compromised as the level of tension has risen and staff control has seemed less certain.

The programming at WMCC is guided by the BMS (Behavior Management System). The multi level system offers youth graduated rewards and consequences. Each level is designated by a color band which the youth wear on their wrists to identify the level they

are currently on. Each day the youths' behavior, progress, set backs, accomplishments, challenges, frustrations and goals are evaluated. Each day every youth has the chance to advance to a higher level, or lose a level or levels as indicated by evidence of the above. WMCC has also implemented "pod of the week" if a pod is deserving of that distinction. Earning pod of the week is celebrated with special activities for that unit.

WMCC was originally designed to function not only as a detention facility but also as an assessment center. This has been difficult to achieve as basic supervision must take priority.

- **Unabated for 30 Days or More:** Some youths remain in detention at WMCC for extended lengths of time, and feel that they are doing "dead" time. This issue was first noted in the April-June 2005 Quarterly Report. On 6/20/06 WMCC had a population of 26. Of the 26 youth half of the population, 13 youth had lengths of stay over 30 days; 32, 33, 33, 33, 35, 42, 43, 43, 55, 55, 56, 57, and 74 days. Of the 13 youth 3 were pending a court hearing, and 10 were pending a placement. WMCC has worked in conjunction with DJS Area III Community Services. A joint meeting is held every Tuesday to try to expedite youths' movement through detention and into placement as determined by the adjudication and disposition process.

Response:
A weekly confinement review unit meeting is held at the WMCC each Tuesday afternoon.
Several months ago a full time Case Manager Specialist was assigned to WMCC to intensify our efforts to move youth beyond detention.
The length of stays for youth have decreased and Region Three is moving youth in an efficient manner

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

FACILITY AND MAINTENANCE:
- **Unabated for 30 Days or More:** Additional security fencing of the outdoor recreation area has finally taken on a high priority as a result of the youth escape on June 28th. Though this concern had been reported numerous times the Department has responded that sufficient funding was not available. Recent estimates have been submitted, but no new fencing has been constructed as of yet. This issue was first noted in the July-September 2004 Quarterly Report.

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

Response:
Unfortunately, at this time there is some difficulty in matching the replacement fixtures to the existing plumbing.

• **Unabated for 30 Days or More:** All but six of the suicide resistant beds that were to be installed at WMCC are now in place. It is reported that the last six beds will be installed soon.

Response:
All beds have been replaced with the new suicide resistant beds.
The original beds are in storage and will be taken to surplus in the near future.

The sleeping rooms on the East and West sides of the center are being equipped with tinted windows. Lighting and outside cameras also help protect youth confidentiality, and provide added safety and security.

• **Unabated for 30 Days or More:** The control room door is often kept open because of poor ventilation of the room. This presents a potential breech of security. There is no air conditioner provided.

Response:
The maintenance department is assessing the control room to determine the need.

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

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

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

• **Unabated for 30 Days or More:** Many of the Community Case Managers maintain regular contact and visitation with youth at WMCC. Some Case Managers maintain little or no contact. Special assignment youth that have been placed at WMCC especially from Baltimore City have received very little contact from their Community Case Managers. Family members have difficulty visiting WMCC from Baltimore or places even more distant. This issue was first noted in the July-September 2005 Quarterly Report.

• **Unabated for 30 Days or More:** It is the practice on ASSIST to begin the counting of a youth's time in a facility anew each time the youth is transferred to a different

detention center. This practice gives an inaccurate and deflated accounting of how long the youth has actually been continuously detained. This concern was first noted in the July-September 2005 Quarterly Report.

Response:
We will determine how counting time in the facility should be recorded.

THE CHELTENHAM YOUTH FACILITY'S (CYF) maximum capacity is 110. During this reporting period, the facility housed approximately 90-130 male youth between the ages of 12 and 18 in four detention cottages and one shelter care cottage. On May 1, 2006, DJS opened a new committed program in the shelter cottage. The Re-Direct program is a 30, 45, and 60 day program for boys.

The facility operates under DJS Detention Standards, COMAR, and other policies and procedures. This monitor made unannounced and announced visits during this reporting period. The United States Department of Justice also monitors the facility through a Memorandum of Understanding dated June 29, 2005.

STAFFING:

- Population:

The facility is rated for a maximum population of 110. During this monitoring period the population has been as high as 130.

- Staff/Youth Ratios:

Cheltenham has approximately twenty (20) direct care vacancies. The facility administration continues to actively recruit new staff members and is awaiting approval to hire twelve candidates. The new staff could help to lower staff to youth ratios and ease the staff members having to work many hours of overtime to provide supervision during staffing shortages. Currently, staff members are working overtime in order to maintain the 1:6 staff/youth ratios.

Unabated for 30 or More Days:

- The facility has (10) case manager vacancies. DJS states that it plans to provide two case managers for each of the five cottages and intake area. Two case managers have been hired since May.

Response:
We continue to recruit and hire staff as positions become available. We have posted positions on Monster.com and we have put flyers in the Unemployment Office in Prince Georges County. In addition eighty-seven letters were sent to prospective employees who passed the last test. Of the eighty-seven, twenty prospective employees were interviewed. Four Case Mgr. Spec. were hired on 8/21/06 and entered ELT on9/6/06

- Staff Training:

The JJMU issued a Special Timely Report dated June 28, 2006, that cited the alleged falsification of training/overtime documentation and inadequate staff training. Staff members stated that the facility's training coordinator required staff members to study mandated training materials and test themselves while supervising youth. Staff members stated that the Training Coordinator further instructed them to falsify their timesheets by

adding 8 – 16 overtime hours for training that had not occurred. DJS conducted an investigation as a result of the information provided by the JJMU but failed to provide this Office with a copy of the investigative findings. Some of the CYF staff members involved in the investigation reported that they have since attended training classes with certified instructors. One of the JJMU monitors assisted DJS by providing "Reporting Child Abuse and Neglect" training to the CYF staff.

RESPONSE:
Conducted MCTC Training for all staff implicated in this incident. On 8/25/06 5 new staff completed ELT. Ms. Ethel Demby was re-assigned to CYF as the Training coordinator. Seven new staff are presently in ELT (9/6/06). Newly assigned Director of Group Life will monitor overtime.

SAFETY AND SECURITY:

- Incidents of Fights:

The facility had 67 fights during the April - June 2006 reporting period compared to 66 fights during the April - June 2005 reporting period.

Group

1st Quarter	Y on Y	Yon S	Contraband	Disturbance	Escape
Apr 2005	15	1	2	0	0
May 2005	22	0	4	0	0
Jun 2005	29	0	0	0	0
Total	67	1	6	0	0

2nd Quarter

Apr 2006	19	0	1	0	1
May 2006	21	1	2	0	0
Jun 2006	27	0	0	0	0
Total	66	1	3	0	1

Y on Y = Youth on Youth Physical Altercations;
Y on S = Youth on Staff Assaults

- Escape Incident:

On April 14, 2006, two youth escaped from the facility by driving a State- owned vehicle through the perimeter fence. The youth were being supervised by a female staff member while delivering bottled water to the Administration Building. When the staff member allowed the youth to exit the building alone, the youth drove the vehicle through the fence, ran across the street, and were caught by facility staff members. The youth stated that they found the key to the vehicle lying on the ground outside of the female staff member's office. The youth were treated at a local emergency room for minor injuries suffered during the escape. Since this incident CYF has implemented a policy that all keys must be check-in and secured at the front security gate upon entering the facility.

EDUCATION:

- Recently the facility filled a school principal position.

- The youth were attending classes during the June 5, 2006 visit. The classes appeared structured and the youth were attentive to the subject matters.

PROGRAMMING:

- On May 12, the facility sponsored "Area Five Day" by inviting Community Services workers into the detention center for a cookout with the youth. The Case Managers spent time with the youth on their caseloads.

- On June 6, the facility sponsored an Open House to unveil "The World of Hope" mural that was designed and painted by a group of CYF youth. An artist from the group, Class Acts Arts, that provides drawing lessons for the youth assisted with the creation of the mural. Fifteen youth worked on this project which took three months to complete. The mural is displayed on a wall in the facility school building. Many community members attended the Open House to show support for the youth and their hard work. The JJMU also showed its' support by attending the Open House.

- Also on June 6, 2006, DJS Secretary, Kenneth C. Montague, Jr. announced the new horticulture program at CYF where Wal-Mart has agreed to provide gardening tools and supplies to the school. The youth and staff will design and plant gardens on the grounds of the facility.

RECREATION:

- Recreation Logbook:

A check of the recreation logbook for the period of May 19-30 showed no mention of recreation activities. The logbooks prior to- and subsequent to- that period were very detailed and systematic. The JJMU questioned the disparity of the activity and in the thoroughness of recordkeeping in the time period of May 19-30, 2006. The JJMU was informed that the recreation coordinator was on vacation for that time period and a replacement staff member coordinated the activities. According to the recreation logbook, it would appear that the youth had no required physical activities provided during the period of May 19-30, 2006. There appears to be a lack of contingency planning for skilled recreation staffing during the absence of the normal recreation coordinator. According to DJJ Detention Standards the youth within these facilities must have (1) hour of large muscle group activity each day.

Response:
Corrective Actions were taken immediately and this issue has been corrected by the Recreation Supervisor

HEALTH AND MEDICAL:
Unabated for 30 Days:

- Nursing Staff:

Nursing staff complain of contract nurses showing up late for work, if at all, resulting in a shortage of staff.

- Hygiene Materials:

On May 31, 2006, a JJMU monitor conducted an inspection of the supply closets in each cottage. The following deficiencies were cited:

1. No T-Shirts
2. No clean towels
3. No showering soap

4. Only four tubes of toothpaste in Cornish Cottage
5. No cleaning supplies
6. No trash bags
7. No socks
8. No washcloths

Response:
These issues have been corrected.

FACILITY MAINTENANCE:
Unabated for 30 Days

- Facility Security:

Due to the recent incident in which a vehicle was able to drive through the facility's fence along the back gate area, facility administration has requested that guardrails line the outside of that fence area. The guardrails could serve as a deterrent for vehicles or make it harder for a vehicle to be driven through.

- Facility Maintenance:

On May 31, 2006 the air conditioning unit in Henry Cottage was not working properly in the sleeping units. The heat in the bedrooms was, in the monitor's opinion, unbearable. According to the superintendent, fans were being used to cool the hallways of the cottage while the youth were sleeping. The problem posed by this response to the lack of air conditioning was that the doors of the individual sleeping units are closed at night, therefore, negating the benefits of the air circulation. The unit has since been repaired. In order to minimize the effects of future hazardous conditions such as this, it is recommended that the facility's administration devise contingency plans for handling heating and air conditioning failures.

ADVOCACY/INVESTIGATIONS/MONITORING:

- Grievance Summary Reports:

DJS has stated that, beginning February 2006, the Child Advocates would no longer prepare Monthly Grievance Summary Reports. However, the JJMU respectfully requests copies of the monthly grievance summary reports that were prepared every month from November 2003 thru January 2006. The reports summarize the Child Advocate's key findings of living conditions within Cheltenham.

THE J. DEWEESE CARTER CHILDREN'S CENTER is a detention facility with a design capacity for 15 male youth. The Department of Juvenile Services (DJS) website listed the rated capacity at 15 also. In February, the DJS website was changed to state that the capacity for this facility is now 27 youth. The facility operates under DJS Standards of Detention and other DJS policies and procedures. Monitors conducted announced and unannounced visits to the facility during this reporting period.

STAFFING:
Unabated for 30 or More Days:

- The January through March, 2006 monitoring report cited six vacant direct care positions. Staff members complained of working many hours of overtime to provide supervision of the youth. Supervisory staff members also worked overtime to provide supervision of the youth for the facility. In May and June, the facility administration

filled four of the six vacant direct care positions. The Superintendent is awaiting approval to hire two potential applicants to fill the remaining vacancies.

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

- A new case manager was hired in June and the Superintendent is planning to fill a second case manager position.

SAFETY/SECURITY:

- Incidents:

During this reporting period staffing levels increased and the number of violent incidents within the facility decreased. The correlation substantiates DJS' Detention Standard 5.1.5.5 that states "staffing levels shall ensure the proper supervision and safety of the residents." The following chart illustrates the number of incidents that occurred during the January - March 2006, along with the current reporting period:

	Use of Force	Youth on Youth Assaults	Group Disturbances
January 2006	**2**	**0**	**0**
February 2006	**2**	**4**	**0**
March 2006	**2**	**4**	**1**
April 2006	**0**	**1**	**1**
May 2006	**1**	**1**	**1**
June 2006	**0**	**1**	**0**

The April 6th group disturbance occurred after six youth were transferred to Carter from the Alfred D. Noyes Children's Center in Rockville. A fight occurred during breakfast that involved approximately 18 youth. Youth also threw chairs and food trays. The Chestertown Sheriff's Dept. and Maryland State Police responded to the facility. Some youth received minor injuries and all four staff members were treated at a local emergency room for swollen arms and shoulder injuries.

The May 13th group disturbance was the result of a dispute between youth from Wicomico County and Baltimore City. The youth were fighting one another and threw chairs. Police were called to assist but staff gained control of the facility by placing all youth in their rooms before the officers arrived.

At the May 24th Facility Advisory Board meeting, DJS stated that Carter will be used a last resort for transferring youth from other facilities during a "population crisis". During the June 1st monitoring visit, the total facility population was 27. Of that number, only 7 youth were from the Upper Shore counties. The following chart illustrates from which counties the other youth came:

Number of Youth	County
10	Wicomico
3	Worchester
2	Somerset
1	Dorchester
1	Montgomery
3	Baltimore City

On May 1st, a youth allegedly took a juice from another youth while eating lunch in the dining room. Staff retrieved the juice and told the youth to finish eating his lunch while standing in the hallway outside of his bedroom door. The youth became angry and used his food tray to break two of the windows in the dining room. The JJMU is unaware of DJS policy that allows staff to instruct a youth to eat their meals while standing in a hallway holding their food tray.

- Training:

On May 30th, a youth requested a bathroom break on the overnight shift. Once in the hallway, the youth physically attacked the male staff member and attempted to run out of the housing area. The staff member received treatment from the local emergency room for an injured lip, swollen nose, black eye, and a broken tooth.

- Contraband:

In May, there were two incidents involving youth smoking cigarettes in their rooms. A youth admitted to bringing the cigarettes into the facility during his intake. In another incident a youth had a lighter in his room. It is recommended that staff members receive in-service training on searching techniques performed during intake processing, or a closer monitoring of staff be done by supervisors during these searches.

- Seclusion Logs:

A review of the facility's Seclusion Log Book, during a monitoring visit conducted on June 21st, revealed incomplete recordkeeping. Since April 16, 2006 there were only 10 incidents where the date and time was noted of youth being signed out for seclusions, out of 115 entries. Included in those 115 entries were entries that had no reason for the seclusions at all. This reveals that 105 out of 115 entries in the log book were improperly completed. In addition, a large number of the seclusions were due to the youth refusing to go to school, or youths being disruptive in school. Thought and consideration should be given to the possibility that youth are using seclusion as a means of not attending school.

EDUCATION:

Unabated for 30 or More Days:

- Class Size:

When the population increases over the design capacity of 15, the teaching areas become crowded. The classes are now held in the dayroom and small dining room of the facility. DJS has stated that plans are being considered to provide two modular units for classroom space. One unit would be considered the special education classroom and the other for a general education classroom.

- Vacancies:

In June, the facility operated with one teacher while the special education teacher updated her teaching certification. During this time, special education services were not provided to the youth. Also, the facility has one vacant teacher's aide position. The teacher's aide provides one-to-one education to youth in need of tutoring. The teacher's aide also teaches class in the teacher's absence.

Response:
This is an incorrect statement. Special Education services were provided to the students who required the services.

A contingency plan was in place. Residents IEP's were followed. The Special Ed classes continued under the leadership of the teacher supervisor Ms. B. Johnson who holds an equivalent of a MA degree/APC which qualifies her to teach special education students. The WRAT-3 a screening tool is administered within the 1st 24 hours of detention or the next scheduled school day. All state and Federal laws are followed for each resident with disabilities.

PROGRAMMING:
Unabated for 30 or More Days:

- Recreation: The facility does not have a structured recreation program.

Response:
The facility administration is developing a structured recreation program

Unabated for 30 or More Days:

- The facility does not have a recreation coordinator. In the January through March 2006 monitoring report, DJS stated that the Department "is looking into filling the position".

Response:
We are still looking to fill the position as soon as a position becomes available.

- During a monitoring visit on June 21st, two youth were playing a video game provided by the facility that had a content warning of "Intense Violence," "Strong Language," and "Mature Sexual Themes." It is recommended that all video games, movies and shows be pre-screened for content prior to being viewed by the youth.

HEALTH/MEDICAL:
Unabated for 30 or More Days:

- Health Care Staff:

The facility had one vacant evening shift nurse position. This was cited on the January – March, 2006 monitoring report, and it was stated by DJS that the position no longer exists. Currently one full time nurse provides medical services to the youth during the dayshift and two contractual nurses cover the weekend shifts. Facility staff members stated the facility needs an evening shift nurse to provide medical services to the youth.

FACILITY MAINTENANCE:
Unabated for 30 or More Days:

- Recreation Facility:

The facility does not have a gymnasium. During inclement weather, the youth are not permitted outside and are not given strenuous physical exercise. Per DJS Detention Standards, a minimum of 1 hour of large muscle activity... shall be provided daily." "The large muscle activity shall be conducted outdoors unless weather or other conditions indicate otherwise." The compliance with this standard is not possible, due to the lack of an indoor gymnasium.

Unabated for 30 or More Days:

- Suicide Resistant Beds:

The facility's beds need to be replaced with a more suicide resistant model, similar to the one in the Lower Eastern Shore Children's Center.

ADVOCACY/INVESTIGATIONS/MONITORING:
Unabated for 30 of More Days:

- Grievance Summary Reports:

DJS has stated that, beginning February 2006, the Child Advocates would no longer prepare Monthly Grievance Summary Reports. However, the JJMU respectfully requests copies of the monthly grievance summary reports that were prepared every month from November 2003 through January 2006. The reports summarize the Child Advocate's key findings of living conditions within Carter.

THE LOWER EASTERN SHORE CHILDREN'S CENTER (LESCC) is a State-owned and operated facility located in Salisbury, Maryland that houses males and females between the ages of 12 and 18 years old. The facility operates under the DJS Standards and other DJS policies and procedures. The facility is a 24-bed detention center located on the grounds of the Wicomico County Adult Detention Center and shares its' building with DJS transportation officers, electric monitors, and the fiscal manager for the Eastern Shore.

STAFFING:
In May, a new Superintendent, Derrick Witherspoon, and Assistant Superintendent, Maurice Sessoms, began supervising the facility. Mr. Witherspoon has many years of administrative experience in committed programs. Mr. Sessoms had many years of administrative experience in community services and detention.

Unabated for 30 or More Days

- Vacant positions: During the reporting period, the facility had (9) vacant direct care positions.

SAFETY/SECURITY:

- Population:

The facility's total population did not rise above its rated capacity of 27 during the reporting period.

- Incidents:

The following chart illustrates the serious incidents that occurred in the facility during this reporting period:

1st Quarter	Y on Y	U of F	Y on S	Contraband	Flooding/ Property Damage
Jan 2006	8	3	2	1	2
Feb 2006	4	0	0	0	2
Mar 2006	4	2	4	1	0
Total	16	5	6	2	4

2nd Quarter					
Apr 2006	4	2	1	2	0
May 2006	5	6	2	0	4
Jun 2006	10	12	3	0	1
Total	19	20	6	2	5

Y on Y = Youth on Youth Physical Altercations (fights; U of F = Use of Force;
Y on S = Youth on Staff Assaults; Contraband = Unauthorized Items
Property Damage = Damage to the facility by youth

On May 2, 2006 a youth threw a trash can into the Dining Hall serving line window causing the glass to shatter. On May 10, another youth threw the overheard projector in against a classroom wall causing the glass to shatter. MSP charged both youth with destruction of property. Proper and rapid restraining techniques can minimize the amount of damage caused by youths when explosive behavior erupts.

On May 14, 2006 six youth caused a group disturbance by refusing to go into their rooms at bedtime. All six ran around the unit, jumped on tables, and blocked the doors of the other six youth on the unit to prevent them from going to bed also. Approximately 15 – 20 minutes later, more staff members arrived and they were able to place all twelve youth in their rooms.

On May 18, 2006 a female youth threw the trash can and the youth's personal boxes, broke the telephone for the staff desk, and broke the resident's collect call payphone. Proper and rapid restraining techniques can minimize the amount of damage caused by youths when explosive behavior erupts.

- Weapons/Shanks/Contraband:

During this reporting period staff found a metal object, one sharpened, in two separate youth's bedrooms. Closer monitoring of youth's activities and frequent physical searches can reduce the possibilities of objects such as these from ending up in youth's possession and ultimately into their bedrooms.

- Unlocked Doors:

On June 24, 2006 a female youth was told to go to her room while the staff member assisted staff on another unit during an emergency. Instead of going into her room, the youth entered another youth's room. The female youth was then able to walk over to the boys pod next door because the staff member left the adjoining door open.

On June 28, 2006 during medication pass a youth walked over to the staff desk and pushed the buttons on the control panel unlocking two bedroom doors. The youth then went into one of the bedrooms and attacked another youth. This issue of unsecured control panels was also cited for similar incidents in the October - December 2005 and January – March 2006 monitoring reports. The staff desk must be properly staffed and monitored in order to prevent future incidents such as these.

Unabated for 30 or More Days:

- Documentation:

As cited in previous monitoring reports, the facility continues to lack proper documentation of seclusion in the seclusion logbook.

- Sexual Activity:

On June 20th, a male and female youth engaged in sexual activity while in the classroom with approximately 13 other youth and staff. Staff permitted the two youth to lie on the floor during a movie while the lights were out. The two staff members were disciplined for failing to properly supervise the youth.

EDUCATION:

- The youth are receiving the 5 hours of daily instruction.

PROGRAMMING:

- The new administrators have been working many hours to provide programming during the evening and weekend hours.
- Two religious groups provide programming to the youth and two religious groups will begin this summer.

HEALTH/MEDICAL:

No issues to report at this time.

FACILITY MAINTENANCE:

- Flooding:

On two occasions, youth tampered with the fire sprinklers causing them to activate. Once activated, the dayroom carpet must be professionally cleaned to remove the excess water.

Unabated for 30 or More Days:

- Toilets and Sinks:

DJS has not made a decision as to replacing the porcelain toilets and sinks with a stainless steel model. It is recommended that the replacement be completed as expeditiously as possible, due to the dangers of the sinks and toilets being broken and the pieces used as a weapon.

ADVOCACY/INVESTIGATIONS/MONITORING:

- Grievance Summary Reports:

DJS has stated that, beginning February 2006, the Child Advocates would no longer prepare Monthly Grievance Summary Reports. However, the JJMU respectfully requests copies of the monthly grievance summary reports that were prepared every month from November 2003 thru January 2006. The reports summarize the Child Advocate's key findings of living conditions within LESCC.

THE YOUNG WOMEN'S FACILITY OF MARYLAND AT WAXTER is a State-owned and operated detention/residential treatment facility that houses females under the age of 18. The single bed capacity is 68. The facility is comprised of one detention unit, one pending placement unit, and one secure committed program. Waxter is operated under the Department of Juvenile Services (DJS) Standards of Detention and other DJS policies and procedures.

STAFFING:

Unabated for 30 or More Days:

- Direct Care and Resident Advisors:

The facility continues to be understaffed. There are a total of seven (7) Direct Care positions needing to be filled, (5) Resident Advisors, (1) Shift Commander, and (1) Unit Manager. In addition, there are (3) vacant Direct Care contract positions. There were occasions during monitoring visits that staff members were in the middle of working a double shift.

- The facility administration appears very cognizant in strategic planning and staff training in order to adequately service the youth. There are in-house staff trainings and weekly staff meetings; daily there are briefings with managers and department heads; additionally, there are formal managers' meetings conducted every Tuesday.

- In order to motivate the staff, the administration has conducted Food Service Workers Appreciation Day at Red Lobster Restaurant and Teachers Appreciation Day.

SAFETY/SECURITY:

- The following chart illustrates the serious incidents that occurred during this reporting period:

	Y on Y-P	U of F	Y on S	C
April	**9**	**7**	**1**	**2**
May	**4**	**10**	**6**	**0**
June	**6**	**12**	**2**	**1**

Y on Y-P = Youth on Youth Physical Altercations (fights)
U of F = Use of Force; Y on S = Youth on Staff Assaults
C = Contraband.

- Suicidal Behavior:

On April 2nd, a youth exhibited suicidal behavior by cutting her arm and leg with a toothbrush sharpened into a weapon/shank. Staff removed the item from the youth.

- Youth on Staff Assaults:

On April 30th, a youth exhibiting suicidal behavior stabbed a female staff member in her side with a pen.

On May 22nd, a male staff member was kicked in the groin several times by a female youth.

On May 30th, a female youth hit a male staff member in the head and foot with a chair.

- Contraband:

On June 26th, a staff member found a small plastic bag with suspected marijuana in it. Police responded to the facility and retrieved the bag.

EDUCATION:

- There were several incidents where youth used the educational setting to act out aggressively and display disruptive behaviors.

- Fights and youth challenging staff have taken place in the education trailers.

- As noted in the January – March 2006 Timely Report, the education trailers area has been where past attempted escapes occurred. With disruptive behavior occurring in the education trailers, youth are not able to focus on their education instruction.

PROGRAMMING:

The facility has been enhancing the programming schedule by adding a Book Club and allowing more volunteer organizations to provide services to the youth. Some of the seminars and programs provided to the youth this quarter in addition to the Book Club have been:

1. The Junior Women's League of Annapolis
2. Girls Scouts of America every Monday
3. National Crime Victims' Rights Lecture, conducted by Dr. Lonise Bias (mother of Lynn Bias)
4. Parenting classes through Anne Arundel County Health Department
5. Baby Day- Youth who are mothers were allowed a special visitation by their children
6. Staff vs. Youth softball game and awards ceremony

Unabated for 30 or More Days:

There is still a need for improvement in the recreation program. During visits the youth were observed while involved in recreation time; however, some of the activities appeared to lack organization and structure. The youth appeared to be mostly sitting around and socializing, rather than engaging in physical activity.

HEALTH/MEDICAL:

- Health Care Staff:

During this quarter there was (1) Registered Nurse vacancy filled.

- Mental Health Screening:

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

FACILITY MAINTENANCE:

Unabated for 30 or More Days:

- Showers and Toilets:

As cited in the October - December 2005 Timely Report and the January – March Timely Report, the facility administration reported that five showers and four toilets will be added to the detention unit's bathroom sometime this year. Those installations have not yet occurred.

- The air condition units in the kitchen preparation area were not operational, creating an extremely hot condition in that area. This condition was brought to the attention of the facility Superintendent. Two weeks later the air conditioners were fixed and the situation was rectified.

ADVOCACY/INVESTIGATIONS/MONITORING:

Unabated for 30 or More Days:

This monitor has received no monthly summary grievance reports from DJS. In April of 2006 DJS advised the JJMU that they are no longer producing monthly summary grievance reports. If DJS is no longer preparing these reports, the JJMU requests copies of the monthly grievance summary reports from November 2003 thru January 2006.

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

STAFFING:

- The facility continues to have a dedicated staff with no vacancies.

SAFETY/SECURITY:

The following chart illustrates the incidents that occurred in the facility during the reporting period. No injuries occurred during the incidents.

	Youth on Youth Physical Altercations	AWOL's
April 2006	**2**	**0**
May 2006	**0**	**2**
June 2006	**1**	**0**
Total	**3**	**2**

PROGRAMMING:

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

EDUCATION:

- The youth receive the required 5 hours instructional training.

FACILITY MAINTENANCE:

- The badly worn bathroom, kitchen, and dining room floors have not been replaced. In June 26, 2006, a youth was cleaning one of the bathrooms and his foot went through the badly worn floor. Another youth was using the toilet in the second bathroom and his foot went through the floor also. Although the youth were not injured, the holes in both bathroom floors posed a threat for future injuries if not repaired. The Program Director states that DJS has authorized and accepted responsibility for the repairs of the damaged floors and instructed the Director to contact vendors for estimates. The work should be completed by the end of the summer.

ADVOCACY/INVESTIGATIONS/MONITORING:

- No issues to report at this time.

MOUNT CLARE HOUSE is located on the fringe of downtown Baltimore City. The facility is a two-story house owned by the Department of Juvenile Services and operated by First Home Care Corporation. This is a 12-bed group home that serves male youth (ages 15 1/2 – 18) who have emotional and behavioral problems. The length of stay is nine months to one year. A cook on-site prepares meals. Although licensed by DJS, the group home also contracts four beds with the Department of Human Resources (DHR); four beds with the Department of Health and Mental Hygiene)DHMH) and is governed by COMAR.

STAFFING:

- Mt. Clare House continues to have a seasoned and dedicated staff.

SAFETY/SECURITY:

- On June 12, 2006, one youth ran away from the facility after staff made several attempts to counsel him to stay. Police were notified but youth was not found.

EDUCATION:

- The youth attend the local public schools as required.

PROGRAMMING:

- The youth continue to attend various events within the community. Recently, the youth attended an Orioles game.

- Two youth have full time employment with the Baltimore Downtown Partnership and the Naval Academy.

HEALTH/MEDICAL:

No issues to report at this time.

FACILITY MAINTENANCE:

- Security of Doors:

All exit doors in the stairwell need to be replaced. The doors have buckled and will not close tightly. The second floor door will not close at all. The stairwell leads to

the fire escape route and is a hazard if the doors will not close during a fire emergency.

- Cracked Ceiling:

The ceiling in bedroom #5 is cracked and should be repaired. Mount Clare's maintenance employee has attempted to repair it but the crack in the foundation returns.

- The kitchen is very sanitary.

- Air Conditioning Unit:

The air conditioner should be replaced. A contractor stated that the unit is no longer working on the second floor, causing the bedrooms to be hot at night. The youth sleep in the basement at night on mattresses on the floor because it is cooler on the lower level of the house.

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

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

STAFFING:
During visits made by this monitor there were adequate direct care staffing levels. Schaefer House, however, used to have a full-time maintenance/grounds person. This position is greatly needed again at the facility, especially as so many repairs and projects are left undone. There is one direct-care staff member on long-term sick leave; however, the Director states that this staff absence is not affecting staff coverage.

SAFETY/SECURITY:
Unabated for 30 Days or More:
As cited in the January – March 2006 Timely Report the windows in the dorms do not open. This becomes a safety concern in the event of an emergency where exits through the windows may be necessary.

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

PROGRAMMING:
The programming at Schaefer House consists of individual and group counseling, education, and additional on and off grounds activities. Twice a week youth go the Narcotics Anonymous meetings off-grounds. Youth have complained, however, that they sit too much because the activities lack variety. The Schaefer House does have an arrangement with the YMCA, and several times a week youth are taken to the YMCA for activities and exercise. In addition, the youth occasionally are taken to the movies and bowling. There is new exercise equipment in the basement recreation area, but, as cited in

January – March 2006 Timely Report, the exercise equipment has not been put together. The new equipment has been awaiting assembly for many months.

Schaefer House has implemented an "Upper level" room for youth who demonstrate significant progress in their treatment. Youth assigned to this dorm room have a later bedtime, are able to enjoy television, and they have a radio in their room. This program enhancement is creative and should help youth motivate themselves to earn the privilege. Due to the success of the Upper Level room, Schaefer house is in the process of converting a second room to an Upper Level.

Family visitation is accommodated on Sunday afternoons from 1 to 4pm.

HEALTH/MEDICAL:
DJS provides a nurse who is available on a daily basis for sick call requests. To see the nurse, youth fill out a "Sick Call Request Sheet" and put it in the Sick Call Box.

FACILITY MAINTENANCE:
As noted in the January – March 2006 Timely Report, exterior painting and window repair in particular is badly needed. The Department of Juvenile Services has turned over the new construction needed at Schaefer House to the Department of General Services. DGS hired an architect to develop a plan and a time line for construction. A plan for exterior work was submitted by the architect firm and some repairs are scheduled to begin in August.

Window air conditioners are used. According to the architect, this has contributed to the damage to the windows and to the exterior painted surfaces. Also, the windows cannot be opened, and the screens cannot be cleaned and have accumulated dirt and debris. Not being able to open the screens could be dangerous to youth if there was an emergency. It was reported by the facility Director that the renovations on the exterior windows were to start at the end of June. At the time of this report the work has not begun, but a new start date in August has been articulated.

Unabated for 30 Days or More:

- **Carpeting:**
  The carpeting is in poor condition throughout the facility. It is reported by the facility Director that the carpeting will be replaced by the end of June. At the time of this report the work has not begun.

- **Phone System:**
  There was a prior notation of the telephone system in need of an upgrade. It was reported by the facility Director that the telephone system would be upgraded. As of June 21, 2006 the telephone system has been upgraded and the concern of calls getting through has apparently been rectified.

Unabated for 30 Days or More:

- **Basketball court:**
  As noted in the January – March 2006 Timely Report, there is still no padding on the goal posts. This is a concern due to the hazard of injury to youth.

Unabated for 30 Days or More:

- **Kitchen:**

Though it was reported that the Department has contracted with a cleaning company to complete a power cleaning in October 2005, the kitchen remains in need of a thorough cleaning.

  - The stoves are greasy and dirty.
  - Some of the kitchen cabinets doors have fallen off.
  - Ceiling vents are greasy and dirty.
  - The floor drain under the largest sink is covered in a greasy substance.
  - There is a leak under the small sink.
  - The kitchen floor tile is old and discolored.
  - The ice machine has not worked for over a year.

- **Cafeteria:**

The flooring in the cafeteria needs to be replaced. A requisition has been submitted to the Department and it is reported that the repairs will be completed in August.

As cited in the January – March 2006 Timely Report, caulking is missing around the windows. This allows outside air to come into the room. The ceiling vent covers are missing. It is reported that the windows will be replaced during a renovation taking place in August.

- **Television Room #2:**

As reported in January – March 2006 Timely Report, the flooring in the back television room #2 was soft. This repair has been completed.

Unabated for 30 Days or More:

- **Bedrooms:**

Twenty new dressers and 20 new chests have been purchased and installed. The old beds and remaining chests, however, are covered with graffiti, some of which is gang-related. It was reported that they would be sanded, or painted, but this has not yet happened.

- **2nd floor bathroom and 3rd floor bathroom in need of renovations:**

A plan for reconstruction has been approved and construction has begun.

- **Laundry Room:**

A new heavy-duty washer and heavy-duty dryer have been installed in the hallway behind the kitchen. The concern of the old laundry room being in need of cleaning, as reported in January – March 2006 Timely Report, has been rectified by means of the laundry room receiving the needed cleaning.

Unabated for 30 Days or More:

- **Recreation Room:**

As cited in January – March 2006 Timely Report, the recreation area walls are flaking and need to be sealed and painted. The entire area should be thoroughly cleaned.

Response:
All repairs are on schedule to be completed this fiscal year.

ADVOCACY/INVESTIGATIONS/MONITORING:
The Child Advocate is present in the facility on Wednesdays to address the concerns according to the protocol. The youth have been critical of the grievance process at times, stating that "nothing changes".