

Maryland Office of The
Correctional Ombudsman
Juvenile Oversight Division
FY 2026

First Quarter Report



THE MARYLAND
OFFICE OF THE
CORRECTIONAL
OMBUDSMAN

November 2025

Message from the Correctional Ombudsman

As the newly formed Office of the Correctional Ombudsman, our mission is to operate transparently. It is both an honor and a privilege to present the inaugural Quarterly Report from the Office of the Correctional Ombudsman (OCO), Juvenile Oversight Division (JOD). This report covers the period from July to September 2025. Our mission emphasizes transparency, accountability, and impartiality, ensuring that detained or adjudicated youth within the Juvenile Justice System are treated with fairness, dignity, humanity, and respect. We hope that the recommendations outlined in this report, if implemented, will enhance outcomes and positively impact youth under the care and custody of the Department of Juvenile Services (DJS), while also improving the facilities governed by the Department. Ultimately, this will contribute to the overall enhancement of the Department.

Blending of the Juvenile Justice Monitoring Unit

While the Juvenile Justice Monitoring Unit (JJMU) has undergone an external rebranding to align with the departmental structure as the OCO Juvenile Oversight Division (JOD), it continues to operate with the same level of diligence, trauma-informed care, and professionalism. Our goal remains to achieve the objectives outlined in the December 2024 report. Since the integration of the JJMU into the OCO, we have successfully established the JOD, and our staff continues to uphold integrity and collaboration. We are now current with Juvenile Oversight reports and have enhanced our oversight capabilities.

Goals

Recognizing the intent behind establishing this agency as an independent oversight body, it is essential for OCO not to function like any other agency. Our goal is to maximize all mandated oversight powers granted under SB 134 to forge partnerships that benefit the youth, support their reduced recidivism, and address their treatment needs. OCO's recommendations will be evidence-based and purpose-driven.

STATE OF MARYLAND OFFICE OF THE CORRECTIONAL OMBUDSMAN

JUVENILE OVERSIGHT DIVISION

November 2025

The Honorable Wes Moore, Governor State of Maryland
The Honorable Bill Ferguson, President of the Senate Maryland General Assembly
The Honorable Adrienne Jones, Speaker of the House of Delegates Maryland General Assembly
Members of the Maryland General Assembly
Acting Secretary of the Department of Juvenile Services, Betsy Fox Tolentino
The Honorable Andre Davis, Chairperson Marland Commission on Juvenile Justice Reform and Emerging Best Practices
The Honorable Dorothy Lennig, Executive Director Maryland Governor's Office of Crime Prevention and Policy

Executive Summary

Dear Governor Moore, Senate President Ferguson, Speaker of the House Jones, Acting Secretary Tolentino, Judge Davis, and Director Lennig,

SB 134 established the Office of the correctional Ombudsman, (OCO) as an independent oversight agency over the Department of Public Safety and Correctional Services (DPSCS) and the Department of Juvenile Services (DJS).

The Office of Correctional Ombudsman acknowledges the current leadership at the Department of Juvenile Services and the progress made to improve facility conditions. The Office of the Correctional Ombudsman appreciates the Department of Juvenile Services for meeting with our office and team to build our relationship.

The Office of the Correctional Ombudsman remains focused on addressing persistent and systematic challenges that undermine youths safety, staff effectiveness, and the rehabilitation mission of the Department.

Leadership and Oversight

Effective leadership is essential to creating safe, structured, and accountable environments. Several facilities continue to experience instability in key leadership positions, including vacant, frequently changing, or newly appointed superintendent roles (LESCC, WMCC, GRYC, CYDC). Strong leaders set clear expectations, model professionalism, and hold staff accountable for maintaining appropriate boundaries and consistent care.

Facilities with engaged and experienced leadership demonstrate stronger collaboration, higher staff morale, and provide a better quality of care for young people. The Department should prioritize recruiting and supporting leaders who can build cohesive teams, reinforce accountability, and promote trauma-informed practices across all levels of operation.

Staffing and Training Deficiencies

Staffing shortages remain one of the most significant challenges across facilities. Many programs rely on mandatory overtime, staff drafted from other facilities, and new hires with limited experience. Direct-care staff often receive insufficient training on professional boundaries, de-escalation, and trauma-informed care, and staff are not consistently held accountable for maintaining professional conduct.

High turnover and staff fatigue contribute to lapses in supervision and strained relationships between youth and staff. The Department should implement a comprehensive workforce improvement plan focused on retention, mentorship, and practical, scenario-based training that equips staff with the skills to engage youth safely and effectively.

Contraband

Contraband remains a persistent and dangerous issue, including the introduction of controlled substances such as Buprenorphine into facilities. The presence of drugs has led to medical emergencies, withdrawal symptoms, and operational disruptions. Current search procedures and accountability measures have not been sufficient to prevent contraband from entering secure settings, including BCJJC and Victor Cullen.

Food Services

Food service issues, particularly at Hickey, remain an ongoing concern. Monitoring visits and reports revealed unsanitary kitchen conditions, expired or unlabeled food items, and poorly managed meal preparation. Youth complaints about unseasoned and low-quality meals are common across western Maryland facilities. The Department should ensure that all food service areas meet health and safety standards and that staff are adequately trained in safe food handling and preparation. Youth input about

meal quality should be reviewed regularly, and changes made to ensure meals are both nutritious and appealing to young people.

Physical Plant Conditions and Youth Dignity

The physical condition of several facilities continues to undermine both safety and youth dignity. Common issues include broken or damaged furniture, graffiti-lined walls, and unclean or poorly maintained living units and bathrooms. Youth across all facilities were observed with worn or damaged shoes and limited access to properly fitting clothing.

In western Maryland facilities, Black youth reported that hair and skin care products provided were not suitable for their needs. Soap and laundry detergent caused irritation, and access to barbers or stylists familiar with Black hair care remained inconsistent.

Clean, well-maintained spaces and access to culturally appropriate personal care are essential to supporting youth dignity, self-esteem, and healing. The Department should prioritize regular cleaning, facility maintenance, and the consistent provision of appropriate clothing, footwear, and hygiene products for all youth.

Programming

Youth consistently express a desire for more meaningful programming during after-school and evening hours. Opportunities for recreation, enrichment, and skill-building are limited in many facilities, leading to boredom, frustration, and behavioral incidents.

Programs that promote education, creative expression, personal enrichment, and vocational development help youth build confidence and prepare for successful reentry. The Department should expand structured, engaging programming options and ensure that staff have the training and resources to facilitate activities that support rehabilitation and personal growth. The formation of a Program Team at the Headquarters level is a positive step in this direction.

While the above issues vary by facility, they reflect broader systemic challenges inherent to the nature of youth incarceration. Addressing them will require ongoing commitment, collaboration, and partnership across all levels of the Department and with external stakeholders to create environments that are safer, more humane, and focused on rehabilitation. The Office of the Correctional Ombudsman looks forward to continuing its partnership with the Department to ensure continued progress and meaningful reform inside DJS-operated and licensed facilities.

This report represents a collaborative team effort by the following individuals: Marvin J. Stone, Deputy Ombudsman for Juvenile Oversight, Margi Joshi, Senior Assistant Ombudsman for Juvenile Oversight, Mark Timberlake, Assistant Ombudsman for Juvenile Oversight, Stephanie Biggus, Strategic Data and Technology Manager, Adam Cummings, Executive Administrator, Office of the Correctional Ombudsman, Sally Larsen, Assistant Attorney General Counsel, Office of the Correctional Ombudsman and myself Yvonne-Briley Wilson, Esquire, Maryland Correctional Ombudsman. We respectfully present this report to Governor Moore, the members of Maryland General Assembly and the Acting Secretary of The Department of Juvenile Services as required by Maryland Law.

Kind regards,

Maryand Correctional Ombudsman

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Individual Facility Reports: Detention Centers

Baltimore City Juvenile Justice Center (BCJJC)

Facility Description: Population Served:

Hardware Secure (locked and fenced) Detention Center for Males Juvenile-Detained: Youth Charged as Adults: Pending Placement

Location:

Baltimore, MD

Rated Capacity:

120 Youth

Operated By:

Owned and Operated by the Maryland Department of Juvenile Services (The

Department/DJS)

Baltimore City Juvenile Justice Center, Facility Page

Average Daily Pop:

82 Youth

July-Sept 2025

(43 Youth Charged as Adults; 40 Juvenile-Detained)

Observations

Section IA: Physical Plant Issues

Young people at BCJJC continue to be subjected to unsanitary, unhygienic, and uncomfortable living conditions. Monitoring visits during the quarter identified the following issues:

<u>Rodent infestation</u>: Staff and youth report a persistent mice infestation throughout multiple living units. Youth shared that mice are entering their rooms and even their beds, prompting them to place towels under their cell doors to try to keep them out. One youth remarked that mice are such a constant presence that the youth have started naming them. Supply closets on multiple units were observed to have mice dropping and dirty vents, and youth reported foul odors caused by dead mice on the units.

<u>Heating and Cooling Issues</u>: While attending an unannounced monitoring visit during the quarter, the air conditioning system was not functioning, and unit conditions were uncomfortable, warm and stuffy. Portable fans were observed on the units but not being used during the monitoring walkthrough. After reporting findings and debriefing with administration, facility leadership immediately responded by ordering that cold beverages be provided to youth, fans be available to cool things off on the units, and the temperature be monitored.

<u>Kitchen Repairs</u>: In July 2025, the water line to the kitchen backed up which forced administration to use the staff lounge as a temporary food prep area. The Baltimore City Health Department had to approve an alternative meal plan for the youth during this period (over 2 weeks) which included a combination of catered meals and outdoor cookouts.

In August 2025, the kitchen floor had to be excavated for extensive repairs after pipes providing water to the kitchen burst. During this time, food was transported from another DJS detention center, and youth were served cold breakfasts and lunch for approximately one week.

<u>Unaddressed Graffiti and Broken Windows</u>: Graffiti has been present in the visitation room for nearly a year, and a cracked window in a unit office has been broken for weeks at the time of the visit.

Recommendations:

- In the Department's response to OCO's last report it indicated its plans to expand monthly extermination practices. It should also develop and implement a targeted pest control plan to address the persistent rodent infestation and ensure that maintenance staff follow a regular cleaning and sanitation schedule.
- Repairs to climate control systems, broken windows, and graffiti-covered walls should be prioritized and completed promptly.

Section IB: Medical Services

Young people continue to report inconsistent and at times neglectful medical care.

During one monitoring visit, a paraplegic youth housed in the infirmary was upset because he was left sitting in his own waste (urine and feces). The smell of urine and feces permeated the infirmary area, and the other youth tried to clean the area around the youth to quell the smell. Both the youth and his peers asked the Assistant Ombudsman for assistance in getting the youth's hygiene needs met. After the Assistant Ombudsman initiated a formal complaint, nursing staff began to meet the youth's basic hygiene needs.

In another situation, a youth experiencing breathing difficulties reporting feeling dismissed by medical personnel and became agitated. Staff were called to assist with de-escalation. After the Assistant Ombudsman's arrival, medical staff responded attentively, and the youth calmed down.

Recommendations:

- Nursing staff should be held accountable for providing timely, respectful, and hygienic care.
- Ongoing training should be provided to medical and direct care staff on trauma-informed communication, deescalation, and responding to youth health concerns with empathy and professionalism.

Section IC: Staffing Challenges and Youth/Staff interactions

Chronic staffing shortages continue to strain BCJJC operations. Staff at BCJJC are often drafted to cover double shifts on a frequent basis to make up for staff callouts which can negatively affect staff's mental and physical health and lead to fatigue, diminished supervision, and a heightened risk of negative staff/youth interactions.

Several youths reported that some staff take their stress out on them and engage in unprofessional behavior, including being verbally disrespectful, initiating unnecessary physical restraints, and locking youth in early without cause.

Recommendations:

- DJS should evaluate staff recruitment practices and develop a plan to reduce reliance on mandatory double shifts.
- The Department should explore implementing a wellness and resilience program to mitigate burnout and promote staff well-being.
- Supervisors should consistently reinforce professional standards and provide coaching on positive, developmentally appropriate interactions with youth.

Section ID: Programming

Youth report significant downtime on weekends with few structured activities. A popular incentive room called "positive place" features video games, snacks, and big screen TVs to help youth pass time, however much of the equipment is broken or in disrepair.

Muslim youth do not have equitable access to religious services compared to Christian youth and requested in-person religious support on a consistent basis.

The Department has set up a work program for high school graduates called YOLO which allows youth to earn money through facility jobs. The YOLO program affords youth a meaningful opportunity to gain valuable employment skills. However, there have been challenges with implementing the program at BCJJC and other facilities. Youth have reported that there are delays in receiving and processing their applications for employment and with receiving their pay after release. Only one staff member oversees the registration and payroll process for the entire program which contributes to ongoing backlogs.

Recommendations:

- The Department should ensure all youth, regardless of faith, have equitable access to consistent, in-person religious services.
- Repairs and upgrades should be completed in the "Positive Place" incentive room to support positive youth engagement
 efforts.
- Facility staffing for the YOLO program should be increased to reduce processing delays and ensure timely payment to participating youth.

Section IE: Inventory Needs

Shoes issued to youth are of poor quality, break down easily, and often not consistently replaced. During monitoring visits, several youth on one unit were observed wearing shoes with holes or emitting foul odors.

Recommendations:

• Regular inventory checks should be conducted to confirm that all youth have access to clean, properly fitting shoes and clothing in good condition.

Section IF: Education Services

The Juvenile Services Education Program (JSEP), governed by an independent board and led by a board-selected Superintendent, is responsible for providing educational services inside DJS-operated detention and placement facilities.

JSEP continues to help students achieve academic milestones. During the quarter, six youths completed requirements for their high school diploma.

However, recruitment and retention challenges persist, particularly in the Baltimore and D.C. metropolitan areas, where local public schools offer higher salaries and more favorable schedules, including summers off. There were vacancies for science, resource, and math teachers during the quarter.

Recommendations:

- JSEP should continue targeted recruitment efforts with an emphasis on competitive compensation and professional support for teachers.
- Vacancies in core subject areas such as math and science should be filled promptly to ensure consistent instruction aligned with state standards.

Section IG. Contraband

Controlling the flow of contraband remains a significant challenge at BCJJC. In Incident 185659, a youth search resulted in the recovery of 36 strips of Buprenorphine.

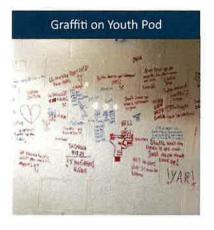
Recommendations:

• The Department should conduct a facility-wide security assessment and develop an action plan to prevent contraband from entering or circulating within the facility.

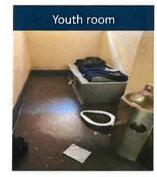
Baltimore City Juvenile Justice Center (BCJJC) Photographic Documentation























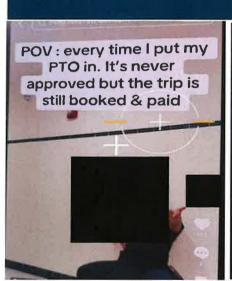




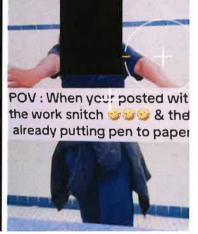
Staff using Tik Toc inside facility











Charles H Hickey, Jr. School (Hickey)

Facility Description: Hardware Secure (locked and fenced) Detention Center for Males

Population Served: Juvenile-Detained; Youth Charged as Adults; Pending Placement

Location: Parkville, MD (Baltimore County)

Rated Capacity: 72 Youth

Operated By: Owned and Operated by the Maryland Department of Juvenile Services (the

Department/DJS)

https://djs.maryland.gov/Pages/facilities/Charles-H-Hickey-Jr-School.aspx

Average Daily Pop: 66 Youth

July-Sept 2025 (44 Youth Charged as Adults; 22 Juvenile-Detained)

Observations

Section II A: Food Services

There are ongoing concerns regarding food services at Hickey. Continued issues include:

- Expired and unlabeled food items stored in the kitchen
- Dirty dish rags and unclean appliances
- Moldy fruit, especially berries
- Food transport vehicles that are frequently broken down and unclean
- Unlabeled staff leftovers stored in refrigerators with youth meal items

Youth also raised concerns about unprofessional behavior by kitchen leadership, specifically the Food Service Administrator. OCO received a report from a formerly detained youth at Hickey during this reporting period. He explained that he experienced a negative interaction with the administrator after expressing his concern about being served a meal that contained an item, he could not eat due to reported food intolerance. The supervisor allegedly questioned the youth, stating, "You eat everything else". Another youth expressed concern about the supervisor's unprofessional behavior toward both youth and kitchen staff.

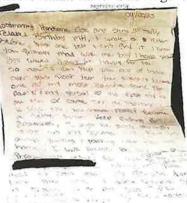
Recommendations:

- The Department should ensure kitchen operations adhere to food safety standards through regular inspections and corrective action plans.
- Food service leadership/managers should receive refresher training in professional communication and responding to youth concerns respectfully.
- All food storage areas and transport vehicles should be subject to routine sanitation checks and documented maintenance schedules.
- Dietary leadership should review supervision practices within food services to ensure accountability and adherence to hygiene and safety protocols.
- Due to the ongoing challenges in Hickey's kitchen and lack of remediation, OCO inquires as to whether the Food Service Supervisor role needs to be re-evaluated in order to meet acceptable health and safety standards.

Section II B: Alleged Staff Misconduct

During the quarter, a "love letter" allegedly written by a female staff member (displayed below) was found in a youth's cell. The letter included a phone number belonging to the staff member (Incident 185773).

The Department's Office of the Inspector General (OIG) is currently investigating the matter. It was reported to the Office of the Correctional Ombudsman that the female staffer is no longer employed with the Department.



Another matter involving a staffer occurred in August 2025 when a youth reported concerning interactions with a teacher. In response, the Maryland Correctional Ombudsman investigated the allegation, interviewed witnesses, and reviewed video footage. The video showed the teacher engaging in a verbal exchange with the youth and throwing a pencil at him. Witnesses, including both direct-care and education staff, recalled the teacher calling the youth "a bitch" and described the teacher as frequently antagonistic and unprofessional in class toward students.

Immediately, following the incident, the teacher began to pack up his classroom for a scheduled re-assignment, did not engage in teaching the students, and shortly thereafter retrieved a broom and began sweeping near the youth and other students. The Ombudsman noted that this action posed a security risk, as the broom could easily have been used as a weapon given the tension between the teacher and student.

Although the incident was almost immediately reported to the school administrator/principal by staff, the Hickey facility administration was not notified by the principal, and the accused teacher was not initially removed from coverage. The teacher returned to the school building at Hickey two (2) days after being out for leave.

Upon the teacher's return, the Deputy Ombudsman for Juvenile Oversight encountered him in the school, while students were passing in the hall and inquired why the teacher was being allowed in the school when per the Department's policy he should have been on no contact.

Following, the Ombudsman and Deputy Ombudsman requests to the Instructional Programs Field Director of the Juvenile Service Education Program (JSEP) led to the teacher eventually being removed from the school while an investigation of the alleged incident occurred, an incident report generated, and proper notifications were made (Incident 185136).

The teacher involved in this incident was relocated per the plans that existed prior to this incident occurring to the Baltimore City Juvenile Justice Center (BCJJC). While initially, there was no contact with students, he has since been approved for and has returned to the classroom.

The mandated reporter in this incident, who was another educator, was questioned for investigation after reporting this incident.

It should be noted that the facility management investigation resulted in a report concluding with a factual finding.

Recommendations:

- The Department should reinforce mandatory reporting procedures to ensure that allegations of misconduct are promptly communicated to facility administration, CPS, OIG, and MSP.
- Educational administrators should receive coaching on accountability and timely response to incidents involving staff
 conduct. Education administrators should review classroom management practices and provide additional training on
 de-escalation, professionalism, and youth engagement.
- Considering the history of student and staff concerns supposedly linked to this teacher, the Department should monitor
 and track complaints regarding educators and other staff to identify concerning behavioral patterns to ensure they are
 properly addressed.

Section IIC: Youth Safety

Youth safety remains a serious concern at Hickey. In one situation, a youth from out of jurisdiction arrived at the facility after being involved in a car accident and sustained a concussion. He was initially placed on a regular living unit rather than in the infirmary, despite his recent injury. The youth later reported to staff and the DJS Child Advocate that he feared for his safety (Grievance 19705). Following his grievance, the Superintendent directed staff to move the youth to another unit. However, staff failed to carry out that directive.

Subsequently, the youth was brutally assaulted by six other youths on the unit (Incident 185862). During the assault, he was repeatedly kicked in the head and sustained two black eyes.

This incident highlights a breakdown in communication, supervision, and compliance with administrative directives. The failure to act on both the youth's safety concerns and the Superintendent's orders placed the youth at significant risk of harm.

Recommendations:

- Ensure immediate compliance with directives related to youth safety and housing assignments.
- Strengthen supervisory follow-up and accountability to verify that safety directives are implemented as ordered.

Section IID. Medical Services

Staff and youth reported to the Assistant Ombudsman for Juvenile Oversight that some nursing staff are slow to respond to sick calls and often display rude, disrespectful, and dismissive behavior toward patients. These concerns were communicated to the DJS Medical Director for follow-up.

Recommendations:

- Nursing staff should be expected to provide timely and respectful care for all youth.
- The Department should implement ongoing training for medical and direct-care staff on trauma-informed communication and empathy in patient interactions.
- Supervisory review of medical response times should be conducted regularly to identify and address delays.

Section IIE: Recreation and Programming Services

Hickey continues to excel in providing high-quality programming for youth. Recreational and enrichment activities include a bike-riding program, facility-wide basketball and volleyball tournaments, chess competitions, game nights, interactive family engagement events, and a mentorship initiative called *Boys 2 Men*.

Section IIF: Contraband

Stemming the flow of contraband inside facilities continues to be a challenging issue. In Incident 185234, a youth was discovered smoking cigarettes in his cell. A subsequent search of his room uncovered a lighter and a pack of cigarettes.

Recommendation:

 The Department should conduct a facility-wide security assessment and develop an action plan to prevent contraband entry.

Section IIG: Transparency Regarding Exceptions to Policy

During the quarter, a youth reported discomfort following a contact with a management-level DJS employee (hereinafter "the manager"). The youth shared his concerns with his mother and later reported them to both facility staff and the Deputy Ombudsman. In accordance with policy, the matter was referred to Child Protective Services (CPS), the Maryland State Police (MSP), and the Department's Office of the Inspector General (OIG).

Consistent with Department policy, staff accused of misconduct are to be removed from youth contact pending the outcome of all investigations. The manager was initially removed from coverage. However, the Acting Deputy Secretary for Residential Services, in consultation with the Acting Secretary of Juvenile Services, granted an exception allowing the manager to return to coverage after CPS initially ruled out the allegation. The Deputy Secretary explained to OCO that the exception was granted because of the high need for the services performed by the manager. Subsequently, CPS reopened the investigation and the manager was again removed from coverage before being reinstated after the investigation was closed a second time.

The decision to grant an exception before all investigations concluded raised concern among facility staff, who noted that front-line employees are typically not returned to duty until all investigative processes are complete. Staff expressed frustration over what they perceived as inconsistent application of policy and potential bias favoring higher-level personnel.

In addition to concerns about fairness and transparency, several staff cited racial disparities as a contributing factor to their perception of unequal treatment, noting that front-line staff at the facility where the misconduct was alleged to have occurred are predominantly Black while the manager and central office leadership are predominantly white.

This situation underscores the need for clearer parameters governing when and how exceptions to removal-from-coverage policies can be made. The current policy grants broad discretionary authority without specifying criteria or requiring documentation of the rationale for exceptions. The lack of transparency around this process, coupled with perceived disparities in treatment, erodes staff confidence in leadership, contributes to perceptions of inequity in the workplace, and undermines the integrity of internal accountability systems.

The official notification of the decline to prosecute and the closure of the State's Attorney's investigation against the manager occurred on October 31, 2025 (Incident #25-185185).

Recommendations:

- The Department should revise its policy on staff's removal from coverage while under investigation to establish clear criteria and documentation requirements for any exceptions granted for "no contact with youth.' All exceptions should be tracked and reported to ensure consistency and equity across staff levels.
- Communication with staff regarding the rationale and parameters for policy exceptions should be improved to prevent misinformation and mistrust.
- The Department should engage in continuous dialogue with staff regarding concerns related to racial equity and trust in leadership.

Charles H. Hickey Jr. School (CHHS) Photographic Documentation



























Cheltenham Youth Detention Center (CYDC)

Facility Description: Hardware Secure (locked and fenced) Detention Center for Males Population Served: Juvenile-Detained; Youth Charged as Adults; Pending Placement

Location: Cheltenham, MD (Prince George's County)

Rated Capacity: 72 Youth

Operated By: Owned and Operated by the Maryland Department of Juvenile Services (The

Department/DJS)

https://djs.maryland.gov/pages/facilities/cheltenham-youth-detention-center.aspx

Average Daily Pop: 64 Youth

July-Sept 2025 (31 Youth Charged as Adults; 33 Juvenile-Detained)

Observations

Section III A: Safety and Security

A new superintendent with a background in case management supervision was appointed to CYDC in January 2025. New leadership has been focused on a collaborative framework involving mental health clinicians, supervisors, and direct-care staff working together to address both individual youth and facility-wide needs to reduce incidents and provide stability and consistency to facility operations

Preliminary incident data suggests that this approach is having a positive impact. The following chart shows facility incident numbers from July to September 2025 compared to the same time last year:

CYDC Selected Incidents	July-Sept 2024	July-Sept 2025	
Average Daily Population (ADP)	69	64	
Youth on Youth Assault/Fight	69	50	
Alleged Youth on Staff Assault	9	11	
Physical Restraint	89	63	
Use of Handcuffs and/or Shackles	12	3	
Seclusion	32	38	
Contraband	12	11	

Youth on youth incidents of aggression declined by 28% and physical restraints of youth by staff decreased by 29% this quarter compared to the same time last year. Use of mechanical restraints also dropped significantly from 12 to 3 incidents.

However, the number of reported seclusions remains concerning. CYDC recorded more seclusions than any other DJS-operated facility this quarter.

	BCJJC	Hickey	CYDC	
Average Daily Population: July-Sept 2025	82	66	64	
Seclusion	16	11	38	

Seclusion incidents at CYDC were more than double that of the largest DJS detention center (BCJJC) and over three times that of the similarly sized Hickey detention center. These figures do not include youth confined to cells due to staff shortages or instances of unreported seclusion observed during monitoring visits (e.g., B Unit, August 28,2025).

Department policy limits the use of seclusion to situations involving an imminent risk of harm or escape and prioritizes the use of less restrictive interventions (DJS Seclusion Policy, RF-720-18). CYDC must continue working to reduce its reliance on seclusion as a means of behavior management.

Recommendation:

Continue promoting collaborative teamwork to improve safety and security while also implementing a targeted
approach to reduce seclusion. Such an approach should include refresher training on the DJS seclusion policy for all
staff in addition to holistic and preventative strategies such as increased staff training on fostering positive youth
engagement and expansion of structured programming that helps youth develop and practice self-regulations skills.

Section IIIB. Failure to Report Staff Misconduct

A senior manager failed to report staff misconduct upon learning of it during the quarter, and facility administration was delayed in providing oversight to address the manager's non-compliance.

Overview of Incident

On September 7, around 5:15 pm, the shift commander was alerted by master control that youth could be seen on camera watching pornographic material in the unit movie room. The shift commander verified on video that youth were indeed viewing sexually explicit content and that a staffer could be seen in the room with youth while the inappropriate content was being shown. The staffer made no attempt to stop or redirect the youth.

The shift commander contacted a senior manager to ask for guidance on how to handle the situation.

The senior manager informed the shift commander that a standard incident report should be generated and instructed the shift commander to keep the involved staffer on-site and that they would arrive at the facility later in the evening to speak to the staffer.

The senior manager arrived to the facility around 11:00 p.m. - on their day off – without notifying facility administration. The senior manager met with the shift commander and involved staffer in the shift commander's office and provided the involved staffer with a document placing the involved staffer under management investigation. They then had a private conversation with the involved staffer outside of the shift commander's office. After this conversation, the involved staffer left the office, and the senior manager and shift commander reviewed footage on the shift commander's computer.

Incident report 185373, labeled Security Contraband Level II, was completed that evening by the involved staffer. The report described youth watching videos displaying a man and woman engaged in sexually explicit activities in the movie room. However, any mention of the involved staffer's presence or role in the incident was omitted.

The following day, the senior manager informed the Assistant Superintendent that an investigation into youth possession of contraband would be conducted.

On September 11, the senior manager conducted an investigative interview with the involved staffer during which the staffer admitted to seeing the screen when pornographic video was displayed. The staffer involved also admitted that they never reported the incident to the shift commander when it occurred.

Despite the senior manager's extensive investigation beginning with their arriving at the facility on the evening of September 7, the senior manager did not complete an incident report regarding the involved staffer's misconduct, nor did they contact Child Protective Services (CPS), the Department's internal investigation unit (DJS Office of the Inspector General [OIG]), and the Maryland State Police (MSP) as required by policy. The involved staff remained in coverage and continued supervising youth.

Seventeen days later, on September 24, the Assistant Superintendent for Operations completed a delayed audit of incidents and reviewed camera footage of the incident for the first time. Upon reviewing the video, he alerted the Superintendent. The Superintendent directed the senior manager to immediately remove the involved staffer from coverage and to notify CPS, MSP, and OIG in accordance with DJS policy. He also directed the senior manager to complete the management investigation that day.

After the directive from administration, the senior manager completed their investigation on September 25, 18 days after the initial incident. Their report noted that video review showed that the involved staffer watched pornographic material with youth, and described the involved staffer as being positioned in a way that appeared to act as a "lookout" for youth while the pornographic video was being displayed. The senior manager completed a new incident report on 9/25 (185675- labeled Security Contraband Level 3) which summarized the video review and the staffer's involvement. CPS was contacted at that time.

At time of writing (November 2025) the involved staff no longer works with the Department. The senior manager also no longer works for the Department.

Management's failure to promptly report staff misconduct, whether intentional or inadvertent, is deeply troubling. It not only exposes youth to potential further harm but also erodes the integrity of facility operations. Delays can also obstruct accountability measures, since staff disciplinary actions must occur within specific timeframes once management becomes aware of serious incidents.

Equally concerning is the lack of timely administrative oversight of incidents. Regular audits of reported incidents by facility leadership can act as a safeguard against mismanagement and help ensure that violations of law and policy are identified promptly. Delays in administrative oversight can also compromise youth safety and weaken facility accountability.

Recommendations:

- All staff, including upper management, should be re-trained on mandatory reporting requirements related to staff
 misconduct with emphasis on the immediate notification to CPS, OIG, and MSP when required.
- Managers who fail to report staff misconduct should not be in supervisory roles and their suitability to work with children should be re-evaluated.
- Systems should be implemented to ensure timely and thorough administrative review of incidents.
- Executive leadership should provide ongoing oversight and guidance to ensure that facility administrators and managers operate with transparency and in compliance with policy and legal mandates.

Section IIIC: Leisure Time Activities and Inventory Concerns

The experience of incarceration often includes long stretches of downtime on the living unit, especially during afterschool hours and weekends. Passive leisure activities - watching movies, listening to music, playing games, cards and video games - remain the primary means by which young people cope with boredom.

CYDC continued to experience ongoing issues with broken TVs, games systems, and radios that often take several months to fix or replace, leaving kids without meaningful outlets for their energy and restlessness. As one staffer explained after months on a unit with broken equipment: "They have nothing to do on the unit and then they act out and get into fights."

The facility also lacked a clear system or procedures to distribute, maintain, and upload content to MP3 players. This inconsistency led to frustration among youth, as some received players while others went without. The absence of a defined process and responsible staff to manage the devices also created opportunities for inappropriate content to be added to the players.

In addition to issues with leisure items, some units faced shortages of basic cleaning supplies and hygiene products, including towels, body wash, and laundry detergent. Youth also experienced delays in getting replacement shoes when those issued to them wore out. This is a frequent problem across all DJS facilities as the shoes provided to young people are often of poor quality and deteriorate quickly.

Since late September, improvements have been made with the support and oversight provided by the recently appointed Acting Deputy Secretary of Residential Services and the executive leadership team within the DJS Office of Residential Services. Their involvement has helped to address long-standing problems with leisure and inventory management. The team is working closely with newly appointed CYDC leadership to develop systems to improve operational efficiency and better meet youth needs. Improvement plans to enhance inventory control, programming, and other residential services on units that have experienced issues in the past have been formulated to help address recurring concerns.

Recommendations:

- In conjunction with support from the Office of Residential Services, develop and improve existing processes for the timely issuance and maintenance of inventory and leisure time items.
- Prioritizing the appointment of an Assistant Superintendent over Support Services can help further strengthen oversight
 and improve facility operations at CYDC.

IIID: Recreation Services

Unlike other larger DJS detention centers, there is only one on-site recreation specialist to provide programming at CYDC. The facility at a minimum should hire another recreation specialist to expand available options for young people.

An additional recreation specialist can also help supplement and support the DJS work program inside detention centers called YOLO which allows high school graduates to perform work duties inside the facility in exchange for compensation. Opportunities for participation in YOLO at CYDC have been very limited due to staffing shortages and a lack of initiative to get the program fully running. At other facilities, recreation staff have successfully taken the lead in coordinating YOLO activities.

Recommendation:

 CYDC should prioritize the hiring of an additional recreation specialist to expand youth programming and help establish the YOLO work program.

Section IIIE: CYDC Community Advisory Board

CYDC continues to benefit from an active and engaged community advisory board that connects young people with services, programming, and resources both during their stay at the facility and upon reentry to their communities.

Section IIIF: Education

The school at CYDC celebrated high school graduations for 2 students who completed their diploma requirements.

Through collaboration with the community advisory board, the school partnered with Forged Pathways, a community partner organization, that provided a handful of youth with the opportunity to participate in a Pre-Apprenticeship Program.

Learn more at: Forged Pathways at: https://www.forged-pathways.org/

Recommendations:

 Continuing to expand workforce development opportunities so a greater number of youth can benefit from hands-on learning and employment preparation.

Cheltenham Youth Detention Center (CYDC) Photographic Documentation





Lower Eastern Shore Children's Center (LESCC)

Facility Description:

Hardware Secure (locked and fenced) Detention Center for Females and Males

Population Served:

Juvenile-Detained; Youth Charged as Adults; Pending Placement

Location:

Salisbury, MD (Eastern Shore)

Rated Capacity:

24 Youth

Operated By:

Owned and Operated by the Maryland Department of Juvenile Services (The

Department/DJS)

https://djs.maryland.gov/Pages/facilities/Lower-Eastern-Shore-Children-

Center: aspx

Average Daily Pop:

21 Youth

July-Sept 2025

(5 Youth Charged as Adults; 16 Juvenile-Detained)

(10 Girls; 11 Boys)

Observations

LESCC has been led by a highly experienced superintendent who has emphasized a collaborative, team-based approach involving all divisions of facility operations to promote a stable facility environment that is responsive to youth needs. The facility has continued efforts to minimize the use of potentially traumatizing practices such as seclusion and mechanical restraints (handcuffs and/or leg irons) on children and young people. During the quarter, mechanical restraints were not used on youth and seclusion occurred only twice.

In August 2024, the superintendent was promoted to an executive-level position within the DJS Office of Residential Services. The assistant superintendent has since assumed the superintendent's responsibilities in an acting capacity.

Section IVA: Incidents and Staffing Challenges

LESCC had a significant increase in youth-on-youth assaults and fights and physical restraints during the quarter when compared to the same period last year. Both categories more than doubled.

LESCC- Select Incident Categories	July - Sept 2025	July - Sept 2024
Youth on Youth Fights and Assaults	25	11
Physical Restraints	72	33

This rise in incidents has taken a toll on staffing and contributed to burnout, injury, and coverage challenges particularly for vulnerable youth requiring intensive supervision. On several occasions, staff experienced delays in receiving aid during calls for assistance. At times, administration was required to respond directly to incidents due to insufficient staffing.

Section IVB: Systemic Shortcomings in Meeting the Needs of Youth with Complex Challenges

Two girls with severe mental health challenges and limited family support accounted for the majority of incidents at LESCC during the quarter. LESCC often receives vulnerable young people, including dual-system youth involved in both the child welfare and juvenile justice systems, due to its smaller size and ability to provide more individualized attention.

Youth who have experienced system involvement in both the child welfare and juvenile justice system often have complex mental health and trauma-related needs, including histories of sexual and physical abuse and neglect, that require

specialized psychiatric services well beyond what detention centers are designed to provide. Detention environments can often exacerbate existing mental health conditions and heighten the risk for deeper and more prolonged system involvement. Staff are not adequately trained nor is the setting appropriate to provide the level of care these youth require. As a result, managing behavior and keeping kids safe while maintaining an overall stable facility milieu can be extremely challenging.

One of the two vulnerable youth entered residential treatment through the child welfare system in 2020 at age 13. After an incident at her most recent residential program, she was charged as an adult and detained at LESCC in late July 2024 (at age 16). It took eight months for her case to be transferred to juvenile jurisdiction, and she has now been waiting more than seven months for placement, resulting in more than sixteen months of continuous detention. Placement options for this girl remain extremely limited.

The second youth was detained at LESCC in May 2025 at age 14 following an incident that occurred in her home. She has an extensive history of mental illness including multiple hospitalizations for suicidality and was found not competent but eligible for attainment services. She is committed to the Maryland Department of Health (MDH) but remains detained at LESCC because of the lack of available MDH facility space. During her detention, she has accrued an additional charge.

Both young people require one-on-one supervision and frequent breaks from the unit to help them regulate their emotions and behavior which places an additional strain on staffing resources.

The plight of these two girls underscores the State of Maryland's severe shortage of behavioral health resources, including residential treatment centers, therapeutic group homes, and intensive community-based treatment programs, for children and youth with intensive mental health needs and severe behavioral challenges.

Section IVC: Staff Accountability and Administrative Audits

Despite staffing challenges and leadership transitions, LESCC administration must ensure that incident audits and related staff accountability are conducted promptly and consistently.

During a monitoring visit on October 7, the Assistant Ombudsman identified incidents requiring administrative follow-up:

In Incident 185648, a staffer was seated eating inside a classroom when a youth approached him and began arguing with the staffer. The staffer stood up and approached the youth and the two continued exchanging words. The staffer did not call for staff assistance to help de-escalate the situation and instead abruptly restrained the

exchanging words. The staffer did not call for staff assistance to help de-escalate the situation and instead abruptly restrained the youth to the ground, pushed the youth's head into the floor, and sat on top of the him while he was restrained in a prone position as he waited for a response to staff assistance (which he initiated only after the restraint). The other two youth in the room can be observed trying to pull the staffer off the youth.

Department policy mandates that physical restraints only be used as a last resort after all non-physical de-escalation methods have failed. The monitor raised concerns about unnecessary use of force and use of unauthorized restraint techniques. The incident was referred to Child Protective Services, the Department's Office of the Inspector General, and Maryland State Police in accordance with the DJS policy on allegations of staff misconduct following discussion of the monitor's concerns.

In Incident 185736, a staffer can be observed arguing with a youth while other staff tried to separate the staffer from the youth. A staff witness reported that the staffer called the youth "a bitch" several times and told the youth his mom was a bitch. The staff did not heed their colleagues' several requests to disengage from the situation and continued to argue with the youth. The monitor requested that the facility pursue accountability for the staffer's inappropriate conduct.

Regular and timely incident audits by leadership are essential to protect youth, uphold staff accountability, and ensure that potential policy violations are addressed promptly. Leadership bears responsibility for maintaining these standards even during staffing challenges and periods of transition.

Section IVD: Investigation Delays

The Office of the Correctional Ombudsman received a completed investigation from the DJS Office of the Inspector General (OIG) on Friday, November 14, 2025, at 3:32 p.m. The initial incident occurred July 16, 2025, at The Lower Eastern Shore Children's Center (LESCC), incident number 184619, Security Contraband and Sexual Abuse Allegations, Staff on Youth Misconduct.

On July 16, 2025, the father of a youth who had recently been released from LESCC reported to a DJS Community Case Manager that his daughter alleged she had been given a marijuana "gummy" by a staffer at LESCC while she was detained there. He also reported that he believed his daughter had been having telephone communications with a male staffer at LESCC since her discharge on July 11, 2025. The father did not have any contact information or a name of the LESCC staffer at that time. The DJS case management unit completed an incident report regarding the allegations, which was entered into the database on July 17, 2025.

On July 23, 2025, a week after the initial allegation was made, it was reported that a DJS Investigations Supervisor who was reviewing the database saw the incident report and requested additional information on this incident. On July 29, 2025, 13 days after the initial allegation was made, the DJS Director of Investigations requested that LESCC conduct and complete a management investigation report regarding the incident.

On August 6, 2025, DJS investigations staff received multiple screenshots, taken from the youth's telephone and provided by the youth's father. According to the report, the screenshots showed multiple text messages between the youth and a male LESCC staffer and a picture of the staffer. Having this information, LESCC administration removed the staffer from coverage on August 7, 2025, and Child Protective Services (CPS) was notified on August 8, 2025.

On August 12, 2025, according to the report, DJS received over 100 screenshots taken from the youth's cellphone showing the youth and male staffer's communications, provided by the youth's father's girlfriend. The screenshots showed multiple text messages between the youth and staffer, reportedly including nude photos of the youth that had been sent to the staffer. On August 12, 2025, Maryland State Police (MSP) were contacted and DJS started an investigation, incident 184619, Security Contraband and Sexual Abuse Allegations, Staff on Youth Sexual Misconduct with the initial reporting date of July 16, 2025.

Additionally, the youth's father reported the following to DJS: While his daughter was in detention at LESCC, the youth's mother connected her on a three-way telephone call to a male individual who told the youth, "I am not in today and will see you when I get back." Since his daughter had returned home, he suspected that she had been talking to a male staff member on the phone, and had heard a male voice on the phone with her saying "I miss seeing you every day."

The OCO has learned that the male staffer allegedly involved in the incident was released from duty on August 14, 2025, and, as of the submission of the OIG's report on November 10, 2025, the case remained under investigation by the Maryland State Police.

OCO did not receive OIG's investigative report on this incident until the afternoon of Friday, November 14, 2025 – 120 days after the incident came to the attention of DJS on July 16, 2025. The OCO understands that the OIG investigation was submitted to DJS 4 days earlier, on November 10, 2025, and that therefore the completed report was not available for review until November 10, 2025. However, the OCO notes that a 120-day delay in receiving this information hinders the OCO's ability to conduct its mandated oversight and reporting role.¹

The OCO further notes that a period of 13 days elapsed after the youth's father reported the alleged misconduct to DJS before DJS requested that LESCC conduct and complete a management investigation report. It is unclear what led to this delay. During this time, the staffer allegedly involved in the incident went unidentified and continued to work at the facility and

¹ The OCO understands that the OIG appears to have placed its investigation on hold for several months at the request of the Maryland State Police, who were conducting – and continue to conduct – a criminal investigation. The OCO posits that, in such situations, it would be prudent for the OCO to receive notice that an OIG investigation has been initiated, but will be delayed, and to share with the OCO the incident reports and related records that exist at that stage. That is especially true where, as here, DJS has already made disciplinary decisions (in this case, the termination of employment of the staffer allegedly involved) before the completion of the OIG's investigation.

presumably have contact with children. The OCO recommends that in the future DJS launch an investigation, or at minimum, an inquiry, immediately upon receiving allegations of this nature.

Recommendations:

- New leadership should maintain a collaborative team approach and prioritize consistent administrative oversight
 including fulfilling their responsibility to conduct regular and timely audits of incident reports to ensure adherence to
 policy and staff accountability.
- The Department should develop strategies to address staff burnout and ensure adequate coverage during investigations and periods requiring 1:1 supervision.
- Statewide, there is a need to increase the availability of residential treatment, therapeutic group homes, and community-based behavioral health programs to reduce the use of detention for youth with severe mental and behavioral health challenges.
- Placement and programming options for girls should be expanded to ensure access to safe and affirming residential care.
- Staff accountability measures should include additional training in trauma-informed care, verbal de-escalation, and authorized restraint techniques to prevent unnecessary or inappropriate use of force.

Western Maryland Children's Center (WMCC)

Facility Description: Hardware Secure (locked and fenced) Detention and Placement Center for

Females

Population Served: Juvenile-Detained; Youth Charged as Adults; Pending Placement; Placement

Location: Hagerstown, MD (Western Maryland)

Rated Capacity: 24 Youth Total

6 Placement Beds

Operated By: Owned and Operated by the Maryland Department of Juvenile Services (The

Department/DJS)

https://djs.marvland.gov/pages/facilities/western-marvland-children-center.aspx

Average Daily Pop: 18 Youth

July-Sept 2025 (6 Youth Charged as Adults; 11 Juvenile-Detained; 1 Placement)

Observations

A new facility superintendent with experience working with both boys and girls was officially appointed to WMCC in late June 2025, the third superintendent at the facility since December 2024. New leadership inherited a deeply entrenched and oppressive culture at WMCC that has long undermined the well-being of both youth and staff

WMCC was formerly an all-boys detention center. The Department converted it to an all-girls detention center in October 2023 and then to a combined all-girls detention and placement center in February 2024 without providing adequate training and resources. Since that transition, WMCC has struggled with chronically low and unsafe staffing levels, strained youth/staff relationships, a chaotic and unstructured living environment that lacks consistency, stability, and safety, and a dearth of meaningful programming and activities.

Staff frequently report feeling ill-equipped to meet specialized and complex needs of girls in the deep-end of the justice system, many of whom have histories of physical and sexual abuse and present with more moderate to severe family and mental

health-related needs than boys. These conditions have fueled staff burnout and low morale, while re-traumatizing girls forced to endure emotionally and physically unsafe and at times inhumane living conditions.

One girls' account captured these systemic issues succinctly. During a check-in with her court worker on July 8 (Incident 184498), she reported that she did not feel safe; that there were not enough staff to run the facility resulting in kids being locked in cells for extended periods of time; that she felt that staff did not want to be there; that a staff person had threatened to beat her up; and that there were few opportunities for recreation and other group activities.

Individual Facility Reports: Placement Centers

The presence of strong, knowledgeable and compassionate leadership is a necessary first step toward transforming WMCC into a facility that is gender-responsive, trauma-informed and capable of meeting the needs of girls and young women in DJS custody.

Section VA: Girls' Equity

Girls in the deep end of Maryland's juvenile justice system continue to receive inequitable treatment compared to boys. Their smaller numbers often result in their needs being overlooked and deprioritized.

Far from Home

The majority of young girls in the deep end of Maryland's juvenile justice system are from the Baltimore and Washington, D.C. metro areas. While securely detained boys and young men are usually held in DJS-operated facilities close to their home communities, there is no regionally based DJS detention or placement center for girls. Girls at WMCC are being held far from their families and communities.

Lack of Placement Options

The Department does not operate a dedicated placement facility for girls. Instead, DJS has chosen to embed a hardware secure placement/treatment program within WMCC detention center by designating one of the pods within the facility to serve as a placement/treatment pod. There are no licensed private providers or DJS-operated staff secure placement for girls in the state and intensive substance abuse treatment options are also scarce. WMCC is the only DJS facility operating both as a detention and placement center, and there is limited outdoor, classroom, and living space for youth as well as limited office space for mental health professionals and other staff. Staff often report issues managing both detention and placement girls in one setting and in such a small facility.

Section VB: Staffing Issues and Youth Staff Relations

Critically low staffing levels continued to plague WMCC in the beginning of the quarter, resulting in youth being locked in their cells for extended periods of time and denied access to mandated recreation and education time. Supervisors were often pulled into coverage and there was often no leadership available to respond to crisis situations or floater staff to bring youth to necessary appointments.

Throughout this quarter WMCC has relied heavily on staff from other facilities to provide coverage. Many of these staff members have been working with girls without prior experience working with the female population and in some cases, without the cultural competence or sensitivity required to address their unique needs. This lack of familiarity and training has

contributed to conflicts between youth and staff resulting in the use of mechanical restraints on more than one occasion.

Additionally, DJS pulled administrative staff who are not trained as direct-care staff to assist with coverage and support at WMCC and required these staff to participate in physical and mechanical restraints.

A staffing crisis in mid-July led to an extreme incident in which girls were locked in their cells for 36 consecutive hours.

The situation started on Saturday, July 12th around 7 pm., when three girls were involved in a physical altercation on a living unit (Incident 184543). Staffers reported that "to gain control of the unit" all girls on the unit were locked in their cells for the remainder of the evening and were not permitted showers. The following day (Sunday), the facility was so severely understaffed that girls remained locked in until Monday morning. During this period, there were extended periods of time when no staff were on the unit at all. Seclusion protocols were not initiated to ensure consistent staff check-ins and periodic follow-up with mental health, medical, and supervisory staff to assess youth well-being and safety.

Two girls were denied basic hygiene and contact with loved ones during this prolonged isolation period (Incidents 184643, 185549, 184664).

In Incident 184643, a menstruating girl with soiled undergarments and bedding asked for a shower when her cell door was opened for an evening snack. She was denied the request, restrained by several staff, and locked back in her cell.

In Incidents 185549 (which occurred around 11:45 am) and 184664 (which occurred around 3:45 pm), another girl was desperate to talk to her family and tried to exit her cell and make a phone call. Each time she was physically restrained and locked back in her cell.

Recommendations

- Adequate staffing is essential to establish safety and ensure access to required and beneficial recreation, education, family engagement, and therapeutic programming.
- It is imperative that new leadership continue to make efforts to stabilize staffing levels at the facility.
- Equally important is the quality of staff—youth relationships. When those relationships are consistent, positive, and
 nurturing, they create safety, foster trust, and help girls overcome adversity and build resilience. Girls at WMCC
 repeatedly request a desire for meaningful connections with staff rather than punitive and control-oriented
 interactions. Improving the relational culture must be at the center of facility transformation.

Section VC: Contraband Incidents

Controlling the flow of contraband remains a significant challenge at many DJS facilities, including WMCC. In incident 185352, a supervisor arrived on Pod A to take blankets to youth rooms and noticed one pack of Narcan on a youth desk. The supervisor staff continued to look around the room where she found a yellow envelope with another pack of Narcan. The supervisor took the packets to medical who confirmed the packets were two unopened packets of Narcan. The supervisor requested medical complete a count of the Narcan packets to make sure they were all accounted for. When the youth was questioned about where she got the Narcan, she responded "that's my business."

In incident 185289, a youth was asked to return to medical to finish her medical intake. During the process the youth was asked if she had a cellphone. The youth initially responded "no." The youth was told by the transporting direct-care staffer

that a female staff was coming to wand her to see if she had a cellphone and complete a pat search. The youth then gave the cellphone to the male staff and was told it would be placed with her personal belongings. The female staffer was directed to complete a pat search to rule out additional contraband. No other contraband was found.

In incident 184672, a youth informed a staffer that she had contraband and would only turn it over to another staffer that she has a good rapport with. The youth pulled out a vape pen and put it in her mouth in front of staff. Staff asked the youth if she wanted her to take the vape pen, the youth responded "no." The youth again responded that she only trusted a particular staff and would give him the vape pen.

Section VD: Trauma Informed Care

Many of the issues and concerns at WMCC during the quarter, described below, reflect a lack of trauma-informed practice and could be addressed through individualized, trauma-responsive approaches.

- O Lack of privacy: During a monitoring visit in early September, youth reported that they were not consistently provided with shower curtains during shower time, leaving them feeling exposed and vulnerable.
- Lack of responsiveness to mental health and medical needs: WMCC created a "chill room" to "provide space for youth to self-regulate, process, and reflect; "take space from others." Youth can request to use the room when they are feeling overwhelmed and need a break. The formerly stark room is outfitted with a rug and had a bean bag chair to create a more inviting atmosphere. During a monitoring visit in late July, a youth was upset and requested to use the chill room to decompress. The staffer on the unit made several radio calls over a 20-minute period requesting an escort to bring the girl to the room but never received a response
- One youth, a nursing mother with medical authorization to pump, was repeatedly denied the opportunity to do so by evening staff, creating unnecessary discomfort and distress.
- Ourtailment of youth voice: Unlike other DJS facilities, youth reported that they did not have access to grievance forms and grievance collection boxes on the unit to report concerns. Grievances were only available in the cafeteria which youth did not have access to during times of restricted movement. As a result, many youth reported that they didn't bother to fill out grievances even though they reported issues to monitors that could have been addressed and resolved through the grievance process.
- Lack of structure and boundaries: Incident 185655 highlights a breakdown in staff supervision and boundary enforcement. Girls were told to line up in the hallway to exit the unit but were left waiting at the door for an extended period while staff awaited clearance from master control. During this time, staff struggled to maintain supervision. One girl moved out of sight and re-entered the dayroom, where a broom and mop had been left unsecured, creating a potential safety risk. Other girls surrounded the staff member at the door, entered his personal space, and grabbed his radio. One of the girls later alleged that the staff member inappropriately touched her during the incident. Staff need training in non-punitive supervision strategies to maintain structure, reinforce boundaries, and reduce chaos on the units.
- Lack of an enriched physical environment: The condition of the physical space mirrors the culture within it.
 During the quarter, some girls, frustrated by the conditions at WMCC, acted out by covering walls with graffiti

and obstructing security cameras with debris and tissue. These expressions of anger and helplessness were made possible by inconsistent supervision and structure.

Creating a trauma-informed environment means respecting youth privacy, accommodating mental health and medical needs, removing barriers to youth voice, fostering structure and predictability, reinforcing boundaries, and beautifying the physical space, ideally with youth input. Together, these practices help build a more humane and responsive culture at WMCC.

Section VE: A Path Forward

Current DJS leadership at the facility and executive level are aware of the challenges at WMCC and have taken steps in a positive direction. The new Superintendent is highly involved in youth care and hands-on in daily operations, which has earned respect from many staff and improved morale and attendance. An Assistant Superintendent with managerial experience in treatment programs has also been appointed and can provide added support.

With stable leadership in place, WMCC has a foundation to effectuate meaningful transformation of the facility culture.

Overall Recommendations for Improving the Culture:

- Continue to stabilize staffing levels and provide on-going guidance and training for direct-care staff on building supportive relationships that foster safety, healing, and growth.
- Recruit supervisory staff with expertise in working with girls and modeling trauma-informed, trauma-responsive care
 and crisis intervention.
- Continue to expand opportunities for girls to learn skills, explore interests, relieve stress, and experience joy through structured activities and programming.
- Implement restorative and healing-centered practices that promote accountability, reliance, and positive peer and youth/staff relationships.
- Facilitate more contact with loved ones. Increased family engagement has been shown to reduce symptoms of anxiety and depression, improve school performance, and motivate positive behavior.
- Girls placed outside their homes deserve opportunities for treatment and growth in environments designed for healing—not within detention centers. The Department should act with urgency to expand community-based residential treatment options that meet the unique needs of girls.

Western Maryland Children's Center (WMCC) Photographic Documentation







Individual Facility Reports: Placement Centers

Victor Cullen Center (Cullen)

Facility Description:

Hardware-Secure (locked and fenced) Placement for Males

Population Served:

Hardware Secure Committed Youth Sabillasville, MD (Frederick County)

Location:
Rated Capacity:

27 Beds

Operated By:

Owned and Operated by the Maryland Department of Juvenile Services (The

Department/DJS)

https://djs.maryland.gov/Pages facilities/Victor-Cullen-Center.aspx

Average Daily Pop:

25 Youth

July-Sept 2025

Observations

Section VIA: Contraband

Contraband remains a serious and escalating problem at Cullen and poses significant risks to youth health and safety. The prevalence of illicit substances, particularly Buprenorphine and cannabis, reflects issues in facility operations and supervision.

In Incident 184960 (July 2025), a youth transported from Cullen to a detention intake unit reported experiencing withdrawal symptoms and disclosed that Buprenorphine was readily available at Cullen. He also later stated to the Assistant Ombudsman that drugs, including Buprenorphine and cannabis, were provided to youth by staff to help them "cope" with their stay.

In Incident 185001 (August 2025), six youth on one unit tested positive for Buprenorphine. A subsequent search of the unit resulted in the discovery of two vape pens.

In Incident 185475 (September 2025), a youth reported to the day nurse that he was experiencing withdrawal symptoms and diarrhea after taking Suboxone. Additionally, it was documented that the youth reported "I don't feel good." The youth had made a similar report the night before stating that he couldn't sleep.

In Incident 185408 (September 2025), staff conducted a visual body search of a youth suspected of possessing contraband. During the search, the youth disclosed that he had just ingested several strips of Buprenorphine. The youth was transported by ambulance to a hospital for emergency medical evaluation.

The frequency and severity of these incidents demonstrate that contraband at Cullen is not an isolated issue but a persistent and dangerous pattern that requires urgent intervention. The introduction and distribution of controlled substances within a secure youth facility endangers residents and undermines rehabilitative objectives.

Recommendations:

- The Department should conduct a comprehensive, facility-wide contraband review to identify points of entry, staff vulnerabilities, and security lapses.
- Strengthen collaboration between direct-care staff, medical, and behavioral health teams to identify and support youth struggling with substance use or withdrawal.

• Reinforce a zero-tolerance stance toward contraband by increasing staff training, monitoring adherence to security protocols, and holding all employees accountable through prompt and appropriate disciplinary action for any violations.

Section VIB: Physical Plant Issues

Facility staff should regularly assess the physical plant to ensure that living spaces remain safe and sanitary. During the quarter, the Assistant Ombudsman observed multiple maintenance issues, including:

- Backed-up urinals covered with trash bags
- Blankets and paper obstructing lights and windows inside cells
- Laundry machines that failed to dispense detergent, resulting in unclean clothing

Recommendations:

Conduct weekly maintenance and facility inspections and promptly address unsanitary or unsafe conditions.

Section VIC: Programming

Youth reported excessive downtime and a lack of structured programming. Equipment intended to support recreation, such as weight machines and video game systems, were broken for extended periods. Access to the popular music room was inconsistent, and off-site activities were limited to a small number of participants. Several youth also expressed a desire for increased therapy sessions.

Recommendations:

- Ensure prompt repair or replacement of recreational and incentive-based equipment.
- Expand access to therapeutic services, recreational programming, and structured activities to reduce idleness.
- Broaden participation in off-ground activities.

Section VID: Youth with Lengthy Stays

In recent years, youth have remained at Cullen for extended periods of time, sometimes for more than a year or until they turn 21. This practice raises serious concerns, as it is inconsistent with principles of rehabilitation and can lead to stagnation and even regression once youth have completed all available treatment and programming options. While placement decisions are made by the courts, the Department should advocate for alternatives to prolonged confinement when rehabilitative goals have been met. At the same time, Cullen should develop individualized programming for youth who remain in custody due to court orders, focusing on advanced skill-building, transition planning, and continued personal and professional growth to ensure their time in placement remains constructive and purposeful.

Recommendations:

- The Department should collaborate with the courts and relevant partners to reduce the use of extended placements by developing community-based or step-down alternatives for youth who have completed all available programming.
- For youth required to remain in placement under court order, Cullen should implement individualized transition plans
 designed to strengthen independent living skills, expand vocational opportunities, and support post-secondary
 educational opportunities.

Section VIE: Case Management Services

A shortage of case management staff during the quarter resulted in delays in reentry paperwork, family phone and virtual calls, and communication with attorneys.

Recommendations:

- Stabilize case management staffing levels to ensure consistent youth access to reentry planning and family communication.
- Implement coverage protocols to prevent gaps in case management services during vacancies or absences.

Section VIF: Inventory and Food Services

Ombudsmen observed youth without proper footwear, including several students attending school in slippers due to the lack of replacement shoes. Another youth requiring a larger shoe size went without properly fitting shoes until monitors intervened.

Youth and staff consistently voiced that meals at Cullen lack flavor and seasoning, and this complaint is common across placement centers in Western Maryland.

Recommendations:

- Conduct regular inventory checks to ensure youth have access to properly fitting clothing and footwear.
- Dietary supervisors in Western Maryland should facilitate youth focus groups to gather feedback on food quality and taste and incorporate youth suggestions to improve flavor.

Section VIG: Education and Post-secondary Services

The Juvenile Services Education Program (JSEP) continues to support students in meeting academic milestones. During the quarter, two youth earned their high school diplomas. Teacher vacancies were reduced with the addition of a Resource and Special Education instructor.

Classes are organized by grade level which allows for targeted instruction. However, student engagement remains inconsistent. Several students were observed sleeping or disengaged during class periods, and instructional time was often not utilized for the full class period.

Communication breakdowns and a lack of coordination between direct-care and education staff also resulted in delays for graduates seeking access to career and technical education.

The Department's YOLO work program at Cullen, which provides high school graduates with the opportunity to earn money through outside employment, represents a meaningful initiative. However, challenges with implementation across most DJS facilities remain. Youth can go for days to weeks without any work opportunities. Youth also reported that hours worked are not tracked properly and that they experienced delays in receiving their pay after release.

Recommendations:

- Strengthening collaboration between education and direct-care teams to ensure they effectively support one another in promoting academic progress and maintaining uninterrupted access to educational programming.
- Provide training to education staff on strategies for classroom engagement and positive reinforcement.
- Improve YOLO program operations to ensure accurate tracking of hours worked and timely payment.

Victor Cullen Youth Center (VCC) Photographic Documentation











Backbone Mountain Youth Center (BMYC/Backbone)

Facility Description: Staff Secure Placement for Males Population Served: Staff Secure Committed Youth

Location: Swanton, MD (Garrett County)

Rated Capacity: 28 Beds

Operated By: Owned and Operated by the Maryland Department of Juvenile Services (The

Department/DJS)

https://djs.maryland.gov/Documents/facilities/Backbone-Mountain-Youth-

Center.pdf

Average Daily Pop:

22 Youth

July-Sept 2025

Observations

Backbone Mountain Youth Center (BMYC) is under the direction of a Superintendent with extensive experience in residential services. The Assistant Superintendent position remained vacant. Leadership at Backbone should emphasize a

collaborative, team-based approach, as many staff reported that case management, mental health, education, and direct-care teams often operate in silos and are eager for greater coordination to enhance youth care.

Section VIIA: Physical Plant

The physical plant at Backbone requires extensive cleaning, maintenance, and upgrades. During monitoring visits, trash and debris were observed around cabins, the 40-seater cabin area was underutilized and unclean, dayroom tables were damaged, and rusted lockers were being used for storage. Phones had also been removed from living units, and camera systems were found to have poor resolution and distorted feeds, which impede effective facility monitoring and incident review.

Recommendations:

- Implement planned upgrades for flooring, furniture, and shoe storage units.
- · Conduct deep cleaning across living and communal spaces.
- Upgrade security camera systems to ensure clarity and functionality.
- Reinstall phones on living units to allow youth to make family calls during downtime.

Section VIIB: Basic Needs and Culturally Responsive Care

Youth at Backbone Mountain Youth Center report ongoing concerns related to personal care items, clothing, and food. They stated that hair and skin care products provided by the facility are not formulated for people of color hair and skin types and are unsuitable for moisturizing or maintaining natural hair textures, leading to dryness, breakage, and discomfort.

Similarly, the soap and laundry detergent supplied reportedly cause skin irritation and rashes for some youth.

Access to barbers and stylists familiar with people of color hair care remains limited due to the facility's remote location in Western Maryland, resulting in long gaps between grooming services that have negatively affected youth morale and self-esteem. Youth also expressed concerns about the quality and flavor of meals and reported that the food lacks seasoning and taste compared to meals prepared in regional DJS detention centers.

Ombudsmen also observed several youth wearing worn-out shoes, including pairs with holes, that had not been replaced in a timely manner.

Recommendations:

- Ensure youth have access to culturally responsive hair, skin, and hygiene products appropriate for their individual needs.
- Establish consistent access to barbers and haircare professionals through on-site visits or community partnerships.
- Conduct regular inventories to confirm all youth have properly fitting, undamaged clothing and footwear.
- Engage youth in providing feedback on food quality and taste to improve meal satisfaction.

Section VIIC: Programming

Youth reported limited programming options during after-school hours and requested more structured recreational and enrichment activities such as bike riding. Youth at Backbone are also not provided with MP3 players to listen to music, unlike at most other DJS facilities, with further limits their access to positive coping outlets and opportunities for leisure.

Recommendations:

- Expand structured programming during after-school hours to include recreational, enrichment, and skill-building activities.
- Provide youth with access to MP3 players consistent with DJS protocols at other facilities.

Section VIID: Staff and Youth Interactions

New direct-care staff are not receiving adequate training, guidance, or mentorship in working effectively with young people. During the quarter, two trainee staff members were involved in serious misconduct.

In Incident 184913, a trainee pulled a youth's hair during an attempted restraint and later threw an orange at the youth, striking him in the face. The staff member no longer works at the facility and was charged with second-degree assault.

In Incident 185318, another trainee was observed engaging in sexually explicit conversations with youth, including sharing personal details about their sex life. The staff member no longer works at the facility.

Recommendations:

- Strengthening onboarding and in-service training to ensure all staff, particularly new hires, receive comprehensive
 instruction on professional boundaries, de-escalation, and trauma-informed care.
- Pair new staff with experienced mentors to provide consistent guidance and reinforce appropriate interactions with youth.
- Reinforce accountability measures and communicate a clear zero-tolerance policy for staff misconduct.

Section VIIE: Contraband

Contraband remains a serious issue. In Incident 185108, a youth entering detention intake from Backbone was found in possession of Buprenorphine strips, which he reported receiving from staff at Backbone.

Recommendations:

- Conduct enhanced staff training on contraband prevention, detection, and reporting.
- Increase supervision and monitoring during shifts.

Section VIIF: Medical Services

Youth report delays in receiving medical care, including one case in which a youth waited over a month for prescription glasses.

Recommendations:

Strengthen coordination with medical vendors and ensure timely access to essential medical items such as glasses.

Backbone Mountain Youth Center (BMYC) Photographic Documentation





Green Ridge Youth Center (GRYC/Green Ridge)

Facility Description:

Staff Secure Placement for Males

Population Served:

Staff Secure Committed Youth

Location:

Flintstone, MD (Allegany County)

Rated Capacity:

30 Beds

14 Youth

Operated By:

Owned and Operated by the Maryland Department of Juvenile Services (The

Department/DJS)

https://dis.maryland.gov/pages/facilities/green-ridge-vouth-center.aspx

Average Daily Pop:

July-Sept 2025

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Observations

Green Ridge Youth Center continues to face significant leadership and staffing challenges. The facility lacks a Superintendent and Assistant Superintendent, and the Department is actively seeking to fill these key leadership roles. In the absence of strong, experienced leadership, the facility has struggled to manage its small population effectively.

Despite serving an average daily population substantially lower than that of the Department's other staff secure placement center, Backbone Mountain Youth Center (BMYC), Green Ridge reported significantly higher incidents involving physical restraints, mechanical restraints, and contraband during the quarter.

Facility	ADP: July-Sept 2025	Physical Restraints	Mechanical Restraints	Contraband
BMYC	22	40	5	11
GRYC	14	51	14	16

Section VIIIA: Staff

Green Ridge current administration reported October 29, 2025, that 11 current staffers have been at the facility under one year. New direct-care staff are not receiving adequate training, guidance, or mentorship in working effectively with young people. During the quarter, a trainee staff member engaged in serious boundary violations with a youth.

In Incident 185253 (August 2025), a supervisor conducting a random camera review observed a trainee staffer allowing a youth to sit on her lap without redirection. The footage showed the youth repeating the behavior while inappropriately touching himself and rubbing his head on her shoulder and neck area, and the staffer failed to intervene. Instead, she was seen tickling the youth and continuing to engage with him inappropriately. The youth later reported to monitors that the trainee staff was attempting to initiate a sexual relationship with him.

The same trainee staffer was also allegedly involved in providing youth with contraband, including vape pens and devices with screens (Incidents 185621 and 185158). The staffer no longer works at the facility. The Department of Juvenile Services conducted an internal investigation, and the allegation of staff sexual misconduct was substantiated according to the document listed below:



Section VIIIB: Green Ridge incident report # 185621 visual body search

Alleged strip search of youth at Green Ridge Youth Center in October of 2025, in a complaint to the OCO Division of Judicial Oversight, a youth alleged that he had been subjected to a strip search by staff at the Green Ridge Youth Center. He alleged that he was instructed by staff to undress in front of them so they could examine him for contraband. He alleged that he was not provided with or offered a paper gown during this search. He alleged that no property was recovered from him during this search.

The OCO obtained and reviewed an incident report written by DJS staff regarding this incident. The incident report stated that, on September 21, 2025, staff watching security footage at Green Ridge Youth Center observed the youth appearing to watch a device, and they verbally counseled the youth to relinquish the device. The report notes that "approval was given by higher chain of command for a visual body search to be performed." (The OCO notes that, under DJS policy RF-712-18(II), a "visual body search" is defined as being equivalent to a "strip search".) The report indicated that the youth eventually informed staff of the location of the contraband, and staff found and retrieved the contraband, which was a "device (MP4) player with a screen." The report concludes with the statement, "Youth... provided information of the location of said contraband prior to staff performing a visual body search."

When contacted by the OCO regarding this incident, DJS administration denied that a "visual body search" had taken place during the incident. It indicated that permission to conduct a "visual body search" was given by the administration, but that "since the contraband was found, the visual body search was not needed and [the] youth... was returned to his group." DJS administration further stated that "a paper gown wasn't provided because a visual body search wasn't conducted."

The OCO notes that a factual dispute exists between the narrative presented by DJS administration and that of the youth who made the complaint to the OCO, as to whether or not the youth was subjected to a "visual body search." Based on the OCO's interpretation of the DJS incident report, the statement that "[y]outh provided information of the location of said contraband prior to staff performing a visual body search" strongly suggests that staff did in fact perform a visual body search after the youth provided information on the location of the contraband. The OCO recommends that, moving forward, DJS staff are trained to write incident reports in a way that leaves no ambiguity as to whether or not youth were subjected to a search.

If the youth was in fact subjected to a "visual body search" during this incident, the OCO notes that the search would appear to violate many of DJS's own policies regarding such searches. Since the contraband had been recovered before the search took place, there would have been no articulated reasonable basis to conduct the search, as required by DJS policy RF-712-18(III)(C)(2)(c)(1). The failure to provide the youth with a paper gown for privacy during the search would have been in violation of DJS policy RF-712-18(III)(C)(2)(c)(4)(e).

The OCO notes that "visual body searches," or strip searches, are invasive procedures in which, when performed in accordance with DJS policy, a youth is instructed, while wearing only a paper gown, to "squat, cough, lift front and then back of gown for visual inspection," and in which staff are required to inspect the youth's hair, mouth and nose. DJS policy RF-712-18(III)(C)(2)(c)(4)(h)-(i). The American Bar Association has noted that "strip searches are harmful and cause trauma to children and youth," and has expressed such concern about their use that it has recommended that they be prohibited except when, among other requirements, "there is probable cause to believe that the child or youth possesses an implement that poses a threat of imminent bodily harm to themselves or others." ABA Resolution Prohibiting Strip Searches of Children and Youth, Except in Exceptional Circumstances at 3, 1 (accessed on October 30, 2025, at ABA Publications. Child Rights Annual 2020). By contrast, DJS policy permits the use of these searches when youth are reasonably suspected of possessing any form of contraband. RF-712-18(III)(C)(2)(c)(1).

The OCO notes that, given the harm to youth that results from the use of strip searches, it is essential that they be performed in accordance with written policy. While in this instance there is a factual dispute as to whether a strip search, or "visual body search," took place, the OCO recommends that, moving forward, DJS staff be trained to write incident reports in a way that leaves no ambiguity as to whether or not youth were subjected to a search.

Recommendations:

- The population at GRYC should remain low until strong, experienced leadership is established. Effective leadership is critical to ensuring structure, consistent supervision, staff accountability, and the development of a safe, trauma-informed program environment that promotes youth growth and stability.
- Strengthening onboarding and in-service training focused on professional boundaries, de-escalation, and traumainformed care.
- Implement a mentorship program pairing new staff with experienced employees to model appropriate conduct and reinforce standards.
- Reinforce supervisory oversight to ensure consistent accountability and early intervention when boundary issues arise.

Individual Facility Reports: Smaller Programs

Morning Star Youth Academy

Facility Description: DJS-Licensed Staff Secure (not locked and fenced) Placement Center

Population Served: Committed Male Youth Ages 13 to 18
Location: Eastern Shore, Maryland (Woolford, MD)

Rated Capacity: Licensed for 24 Youth

(Current staffing levels can accommodate 10 youth)

Operated By: VQ

https://www.vq.com/bv-state/maryland/morning-star

Observations

Program Overview:

Morning Star is a CARF accredited residential program serving DJS male youth committed to staff secure placement. The facility provides youth with substance abuse, mental health, education, enrichment, and recreation services throughout their stay.

Morning Star utilizes a trauma-informed program known as the Sanctuary Model. Therapeutic services are also provided onsite and supplemented by local clinicians from community mental health organizations.

Youth at Morning Star have opportunities to participate in a variety of on- and off-site recreational, volunteer, and enrichment activities. Eligible youth are also able to work in nearby businesses. During the quarter, youth participated in the following activities:

- Field trips to local water parks, state parks, Washington, DC museums and Sky Zone
- Participation in local road running races and athletic events and recreational activities at the local YMCA
- Opportunities to obtain CPR certification and, for eligible youth, a driver's license permit

Dorchester County Public Schools began providing education services to residential students at Morningstar in the fall of 2024. Students attend virtual classes offered through the local county school system. There are two full-time teachers on-site to assist with the instructional needs of students. Students also have access to services available to all Dorchester County public school students including mobile dental and medical clinics that provide periodic evaluations and treatment on-site.

Section IXA: Physical Plant Upgrades

The physical plant at Morning Star is in need of extensive renovations and updates which began over the summer months and are ongoing. The Administration building is currently under renovation and repairs to the on-site swimming pool were completed in August. Several youth participated in swimming lessons following the pool's opening.

Section IXB: Supervision Issues and Security Contraband

Incidents of aggression at Morning Star remain low, and the overall culture is positive and supportive. However, recent incidents highlight concerns related to staff supervision of youth and security contraband.

Incident 184049 occurred in June of 2025 and was investigated by the Department of Juvenile Services throughout June and July. On June 5, youth and staff were transitioning from the administration building to the living unit when one youth exited through a side door of the administration building ahead of his group and absconded from the program. The shift supervisor realized the youth was missing only after the group returned to the living unit. A search of the property was conducted, and when the youth was not located, the facility contacted the local sheriff's office.

Further investigation revealed that the youth approached a neighbor, stated that he was stranded, and requested a ride into town (Cambridge, MD) after absconding from the facility. The neighbor accommodated the youth's request but later discovered that a firearm located in his vehicle was missing.

Two days later, on June 7, the youth's father brought him to a local hospital in Salisbury, MD to seek treatment for a gunshot wound to his foot. The youth was treated and subsequently released to detention.

The DJS Labor and Licensing Unit determined that Morning Star did not provide adequate supervision of youth and failed to maintain direct visual contact with youth. The facility submitted a corrective action plan for the cited violations in late July/early August 2025.

Incidents 184675 and 185597 involved security contraband.

In Incident 184675, a youth was asked by staff about a recent family visit at the facility a few days after the visit occurred. The youth admitted during this conversation that his mother brought his girlfriend to the visit and that the girlfriend gave the youth a nicotine vape pen during the visitation period. Three youth subsequently tested positive for nicotine.

The DJS Labor and Licensing Unit found that Morning Star Morning Star violated its visitation policies by allowing an unauthorized individual to visit the youth resulting in the contraband being introduced into the facility milieu. The facility submitted a corrective action plan for the cited violation in August of 2025. This incident also indicates lapses in supervision during visitation periods.

In Incident 185597, a youth was observed attempting to light a piece of a cigarette with a lighter. The youth was found with a cigarette in his sock during a subsequent search of his person. The youth reported that he was given the lighter and cigarette by a peer.

Recommendations:

 In addition to adherence to corrective action plans, administrators should emphasize during staff trainings and debriefings the importance of always maintaining visual supervision of youth and continue to hold staff accountable for supervision requirements.

One Love Group Home

Facility Description:

DJS-Licensed Residential Group Home

Population Served:

Male Youth Ages 16 to 20 Committed through DJS

Youth in Baltimore City Department of Social Services (DSS) Care

Location:

Northeast Baltimore City

Rated Capacity:

Licensed for outh

Operated By:

Building Communities Today for Tomorrow

https://bettworks.com/

Section XA: Observations

Staff and administrators partner with community-based organizations to provide therapy, education, local employment and enrichment opportunities for youth while they reside in a home-like environment at the One Love group home. Youth with high school diplomas are required to seek employment in nearby businesses while students in high school are enrolled in local community schools to complete high school graduation requirements.

The facility does not maintain an activity or recreation schedule; however, staff organize outings for youth. Recent outings included trips for go-karting, movies, an escape room, and a trampoline park. Youth may also request membership to the local YMCA.

There were three youth committed through DJS to One Love during the quarter; one DJS youth was ejected within a week of arrival for going AWO. Incidents of aggression are rare at the home, however there was a youth-on-youth assault in September 2025 that required police intervention to de-escalate (Incident 185499). One of the youth involved in the assault was later ejected from the group home, and no charges were filed.

Recommendations:

 The program is not highly structured and lacks intensive case management services and support so One Love programming is best suited to older, mature and self-motivated youth, especially those who are preparing for independent living.

Charles H Hickey, Jr. School Shelter Program (Hickey Shelter)

Facility Description:

Non-Secure (not locked and fenced) Shelter Care for Males and Females

Population Served:

Shelter-eligible Youth 11 to 17

Location:

Parkville, MD (Baltimore County)

Rated Capacity:

6 Beds

Operated By:

Owned and Operated by the Maryland Department of Juvenile Services (The

Department/DJS)

Observations

Hickey Shelter is located on the grounds surrounding the Charles H. Hickey, Jr. School detention center. Supervisors and staff from the detention center provide supervision and services to youth at the shelter. During the quarter, the program remained under Community Services but officially transitioned to Residential Care in October 2025.

There are not enough shelter beds to accommodate youth, and because of a waiting list, shelter-eligible youth often remain in detention until space opens at the shelter.

Section XIA: Programming and Education

Youth attend public school in the local community; however, there have been repeated delays in school enrollment. As a result, some youth have spent weeks at the shelter without access to educational programming.

Staff foster community engagement by organizing social events and field trips to local attractions, and there have been recent efforts to increase family visitation. Recreation services are provided by recreation specialists from Hickey detention center, who visit the shelter to lead structured large-muscle and group activities.

Section XIB: Food Services

Meals for the shelter program are prepared and delivered by the kitchen at Hickey detention center. Ongoing quality control issues have continued to affect food provided to the shelter. During the quarter, the kitchen delivered muffins that were molded and had to be discarded by staff.

In addition to provided meals, staff make a consistent effort to keep the small kitchen area stocked with snacks for the youth.

Section XIC: Operations, Contraband and Strip Searches in Shelter Care

Shelter care is intended to be a temporary, less restrictive alternative to detention where youth can receive supportive services in a non-secure environment.

However, there are currently no operational manuals specific to the Hickey shelter, including procedures governing physical restraint and searches.

During the quarter, a staff member informed Ombudsmen that a youth was suspected of providing illegal substances, allegedly obtained from school to other shelter youth. Several youth were subsequently drug tested. According to shelter staff, three youth tested positive for buprenorphine, though official lab reports confirmed only one positive result. Following that test, one youth was subjected to a strip search, during which nothing was found. Another youth later turned in a nicotine vape pen to staff. Staff reported that the three-youth involved went AWOL from the Shelter the same day and were later found in the community and returned to Charles Hickey detention center.

The appropriateness of strip searches in shelter care (which serves as a non-secure, community-based program) raises serious concerns, especially in the absence of clear operational guidance.

Recommendations:

- Partner with Baltimore County Public Schools to avoid delays in school enrollment for youth at the shelter and provide a virtual school option for youth who are flight risks or exhibiting concerning behavior while attending public school.
- Improve quality control measures for meals prepared by the Hickey detention center for shelter youth.
- Develop an operational manual specific to the shelter care program to provide clear guidance on procedures, including restraint and search protocols.
- In the long term, the Department should expand the number of shelter beds to meet demand and consider contracting shelter care to a qualified community-based organization experienced in delivering trauma-informed, youth-centered shelter care.