Office of the Correctional Ombudsman

Juvenile Oversight Division

FY 2026

Second Quarter Report

THE MARYLAND OFFICE OF THE CORRECTIONAL OMBUDSMAN

February 2026

STATE OF MARYLAND OFFICE OF THE CORRECTIONAL OMBUDSMAN

JUVENILE OVERSIGHT DIVISION

February 2026

The Honorable Wes Moore, Governor State of Maryland

The Honorable Bill Ferguson, President of the Senate Maryland General Assembly

The Honorable Joseline Peña-Melnyk, 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

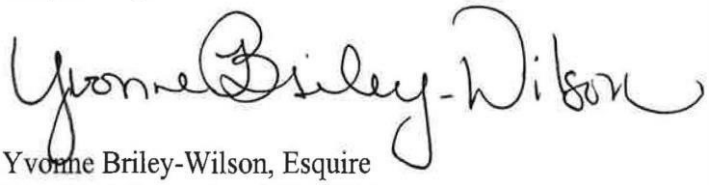
Dear Governor Moore, Senate President Ferguson, Speaker of the House Peña-Melnyk, Acting Secretary Fox Tolentino, Judge Davis, and Director Lenning:

When youth are detained or adjudicated delinquent, it can be a frightening and unsettling time for the youth, his family, victims and all those involved in wishing for the best outcome from that confinement. It is the hope for all involved that the aim of the Maryland Department of Juvenile Services' (DJS) mission to "transform young lives ... " will be achieved with each youth that enters the department's care and custody. While the placement is not intended to be easy or a walk in the park, it is intended to provide accountability and rehabilitation for the youth through appropriate treatment while also providing restoration for victims serving to reduce the risk of recidivism. This can only be accomplished by providing the necessary daily living needs, appropriate treatment, programming, and education.

The Maryland Office of the Correctional Ombudsman (OCO), Juvenile Oversight Division (JOD), formerly the Juvenile Justice Monitoring Unit (JJMU), is charged with ensuring that this mission is carried out within the DJS facilities across the state. The unit is currently comprised of Deputy Ombudsman for Juvenile Oversight, Marvin Stone, Senior Assistant Ombudsman Margi Joshi and Assistant Ombudsman Mark Timberlake. Under the leadership of the Correctional Ombudsman, this dedicated team remains committed to ensuring that the detained and adjudicated youth within the care and custody of DJS are treated fairly with dignity, humanity, and respect. Driven by their commitment and the mission to the mandate of SB 1334, this devoted team remains focused on their responsibility inclusive of ensuring proper medical care, treatment, programming, living conditions, basic living needs, and educational services are provided thereby reducing recidivism and improving the safety conditions for the community upon the youth's return.

This extensive quarterly report provides a summary of the findings and observations demonstrative of the intense and sometimes stressful work required to uncover the challenges and opportunities for improvement within the DJS facilities. It is the goal of JOD/OCO to work collaboratively with the department to ensure that each youth within the care and custody of DJS facilities receives the services necessary for a successful re-entry into the community. JOD/OCO provides recommendation to enhance the integrity of the department. This report strives to provide practical and necessary recommendations for transformative changes.

Respectfully,



Yvonne Briley-Wilson, Esquire
Maryland Correctional Ombudsman

Office of the Correctional Ombudsman
Juvenile Oversight Division

The Maryland Office of the Correctional Ombudsman (OCO), Juvenile Oversight Division (JOD), is responsible for oversight of Maryland Department of Juvenile Services (DJS)-operated detention centers (5), DJS-operated placement centers (4), the DJS-operated shelter care program (1), and DJS-licensed residential facilities (2). JOD has purview over all aspects of facility operations, including physical plant conditions; safety and security; treatment and services (including education, health and mental health care, case management, dietary, recreation, and family engagement services); programming; and staff– youth relationships. This oversight is intended to help ensure that young people in DJS custody are provided with humane living conditions, receive effective care and are treated with dignity and respect.

The Office issues comprehensive quarterly reports summarizing findings from regularly conducted announced and unannounced site visits, as well as document, database, and video reviews. Quarterly reports are intended to promote accountability and transparency within the deep end of Maryland's juvenile justice system and to provide a voice to the experiences and needs of justice-involved young people. Reports include facility-level and systemic recommendations aimed at improving conditions of confinement and the care provided to incarcerated youth. Current and previous reports are available on the Office's website at www.oco.maryland.gov and through the Maryland Department of Legislative Services (DLS) Library, available at: DLS Library - Office of the Correctional Ombudsman

During the second quarter of FY26, JOD regularly conducted in-person site visits to DJS-operated and DJS-licensed facilities across the state of Maryland. These visits included:

- Daytime and evening walkthroughs
- Targeted reviews of incident reports and video footage
- Youth and staff interviews
- Follow-up on concerns raised in prior debriefings and quarterly reports
- Observation of daily operations, programming, and facility climate
- Youth wellness checks and confidential conversations
- Collection of photographic documentation
- Attendance at graduation ceremonies, guest speaker events, and restorative mediations

All site visits are accompanied by verbal and written debriefings with facility leadership, during which findings are discussed and requests for resolution of outstanding concerns are communicated.

In addition to the oversight provided by regular in-person site visits, the Office of the Correctional Ombudsman responds to concerns raised by parents, staff, attorneys, and other stakeholders, and works to facilitate resolution when appropriate. Complaints may be submitted by, or on behalf of, individuals incarcerated within the Department of Juvenile Services either online, by phone at (844) OCOINFO / (844) 626-4636, or by email at jod.oco@maryland.gov.

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Baltimore City Juvenile Justice Center (BCJJC)

Facility Description:	Hardware Secure (locked and fenced) Detention Center for Males
Population Served:	Juvenile-Detained; Youth Charged as Adults; Pending Placement
Location:	Baltimore, MD
Rated Capacity:	108 Youth
Operated By:	Owned and Operated by the Maryland Department of Juvenile Services (The Department/DJS) https://djs.maryland.gov/Pages/facilities/Baltimore-City-JuvenileJustice-Center.aspx
Average Daily Pop: Oct-Dec 2025 (FY26Q2)	70 Youth (41 Youth Charged as Adults; 29 Juvenile-Detained)

Program Overview

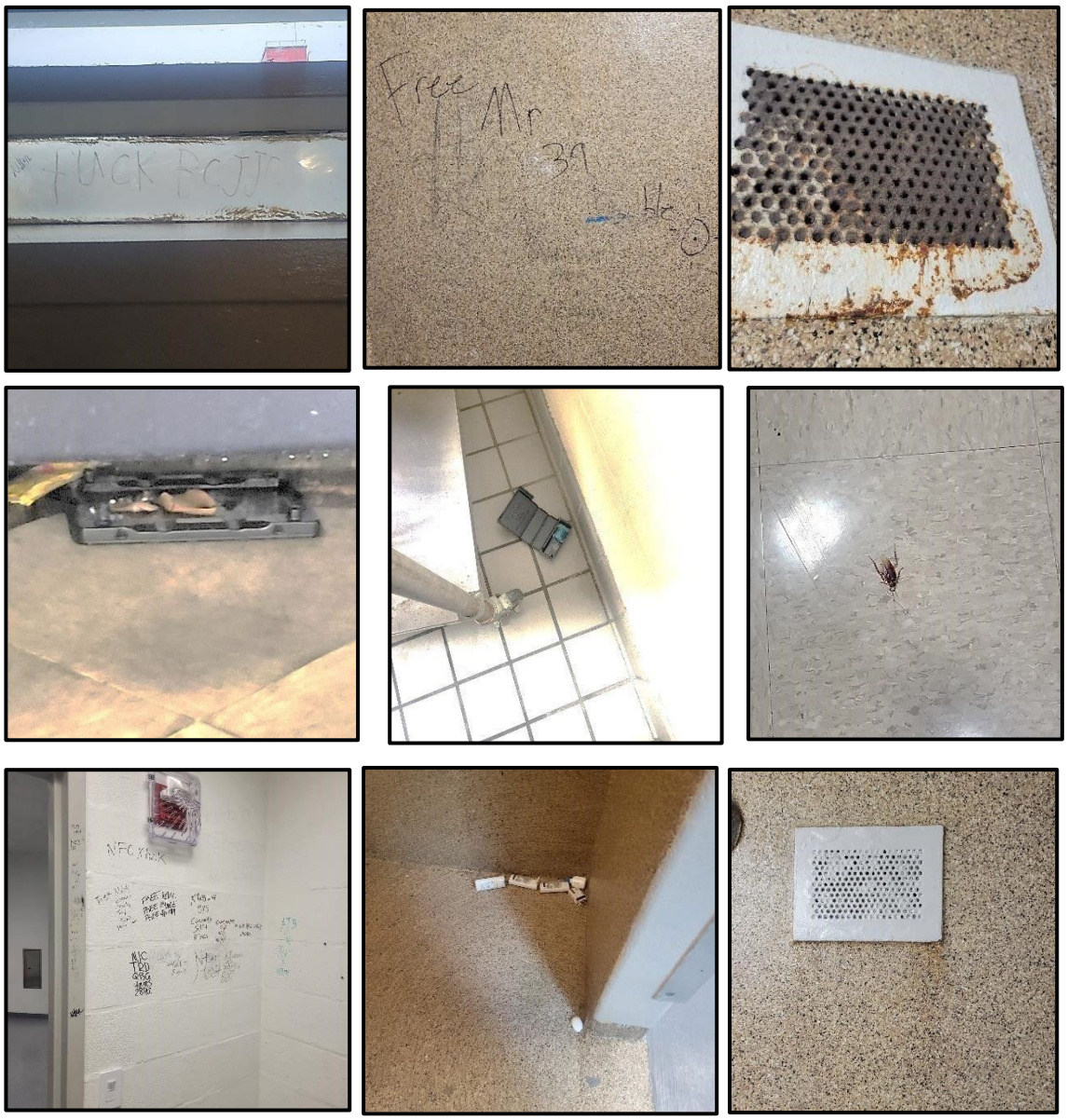
The FY26 Q2 oversight period revealed a facility experiencing persistent physical plant deficiencies, environmental health concerns, and inconsistencies in operational practices, alongside pockets of positive programming and staff engagement. While leadership and staff demonstrated responsiveness in certain areas, many issues identified earlier in the year continued or escalated, indicating the need for sustained, system-level intervention rather than isolated corrective actions.

Facility Operations, Safety, and Physical Plant Conditions

Environmental Health and Sanitation

Across multiple October, November, and December site visits, OCO documented ongoing environmental health concerns, including:

- Rodent activity (mice) reported and observed on multiple units, with youth and staff describing rodents running across rooms, hallways, and stairs.
- Insect activity, including a roach observed in a hallway near the Pods and mouse traps with exposed bait located in food-adjacent areas.
- Graffiti consistently observed in showers, youth rooms, restrooms, stairwells, and medical/infirmary areas.
- Unsanitary conditions, including dirty vents with extreme build up, improperly cleaned bathrooms, and debris in shower areas.

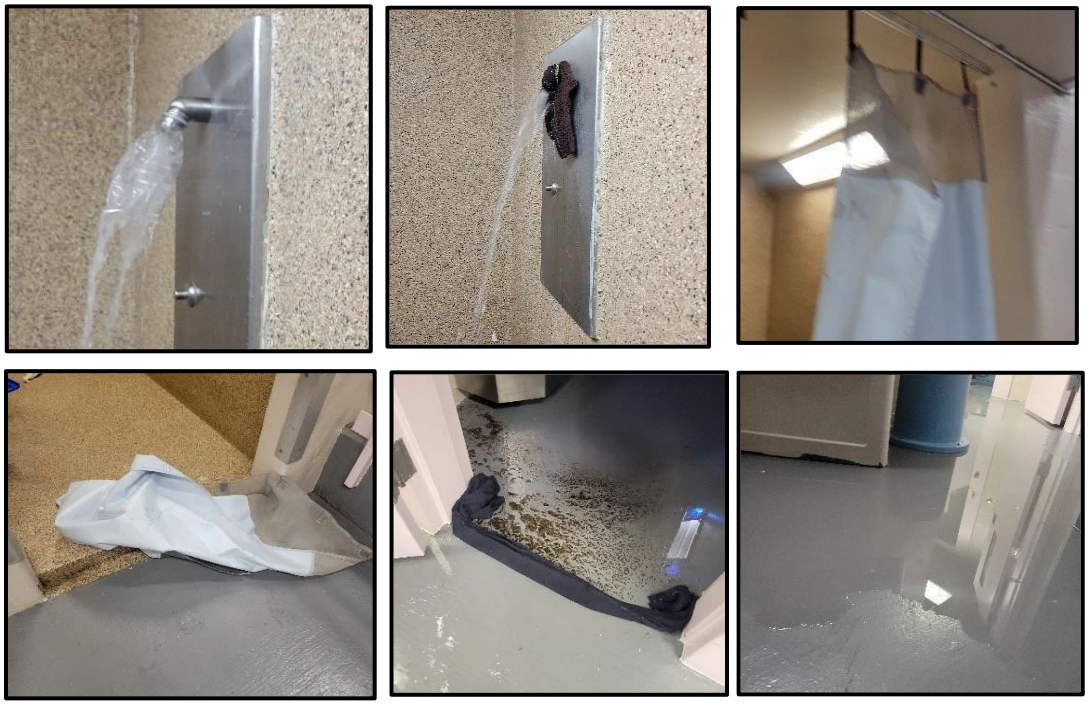


Despite reports that pest control vendors had been changed and discussions about increasing service frequency, conditions observed during Q2 suggest that infestation concerns persisted at a level beyond isolated incidents. OCO notes that the cumulative conditions raised during this quarter reflect an environmental health pattern, not episodic lapses.

Plumbing, Water, and Sewage Issues

Several water-related concerns were documented throughout the quarter:

- Low water pressure and inconsistent temperature in showers, leading to youth attaching improvised devices (e.g., plastic bottles, washcloths) to shower heads.
- Shower curtain failures that repeatedly compromised youth privacy.
- Inconsistent access to drinking water, confusion around water bottle restrictions, lack of cups, and reports of empty or non-functioning water coolers.
- A critical sewage backup and flooding event on Units 20 and 21 (December 19, 2025), with wastewater backing into youth rooms and common areas, creating immediate health and safety risks.

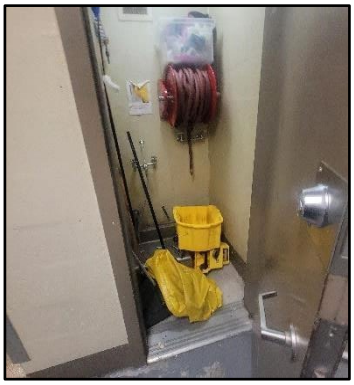


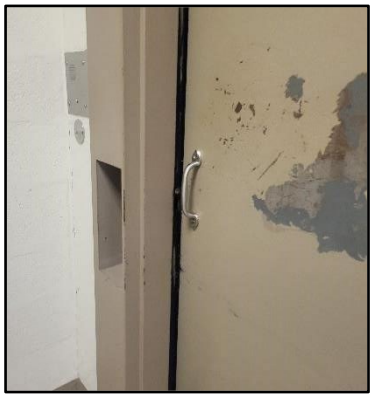
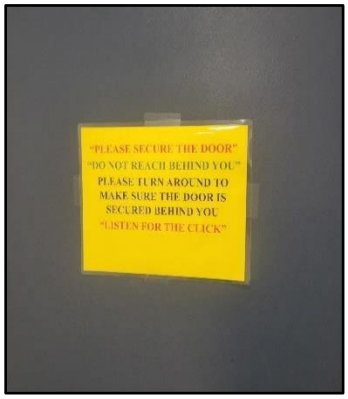
OCO repeatedly requested written clarification on water access policies and sanitation responses from the facility superintendent. The sewage incident, in particular, represented a significant escalation requiring urgent remediation and follow-up.

Doors, Cameras, and Facility Security

Q2 site visits identified recurring safety and security vulnerabilities, including:

- Doors found ajar or unsecured, particularly near the medical corridor and other sensitive areas, across multiple visits.
- Pod doors and intercom systems reported as malfunctioning on D-Pod.
- Parking lot cameras reported as intermittently functioning, with no clear repair timeline provided.
- Janitor closets left unsecured, presenting risks of access to potentially dangerous items.



These issues, when viewed collectively, raise concerns about consistency in security checks, maintenance response timelines, and staff reinforcement of safety expectations.

Medical and Behavioral Health Services

Medical Infrastructure and Documentation

OCO identified repeated operational challenges within the medical department, including:

- Outdated camera equipment for photographing injuries.

- Delayed installation of Plexiglas security barriers at the medical counter, despite prior measurements and known safety incidents involving youth crossing into staff areas.

- Non-functional or inadequate copier and fax equipment, including the absence of color printing, which is essential for accurate injury documentation.

These deficiencies present risks related to staff safety, HIPAA compliance, and the integrity of medical documentation used in incident reviews and oversight.

Medical Care, Communication, and Youth Concerns

Throughout Q2, youth raised concerns regarding:

- Delays or confusion in medical follow-up after injuries or procedures.

- Lack of clear communication regarding treatment plans, infirmary discharge timelines, and medical clearance.

- Family notification gaps, including reports that parents were not consistently informed following medical events or surgeries.

OCO emphasized the importance of timely communication with both youth and families to reduce anxiety, prevent misinformation, and ensure transparency in care delivery.

Use of Force, Safety Incidents, and Operational Consistency

Incident Reviews and Video Monitoring

During October site visits, OCO reviewed multiple incident videos involving restraints, staff positioning, and youth supervision. Observations included:

- Staff positioning that raised concerns about least restrictive practices, including a documented instance of a knee positioned near a youth's neck area.

- Instances where youth were observed engaging in non-instructional activities during school hours without appropriate redirection.

- Situations where staff were present in spaces inconsistent with expected post assignments.

OCO followed up on these reviews with requests for additional camera angles, incident reports, and clarification of procedural expectations.

Fight Response and Staff Direction

Youth-on-youth assaults occurred during multiple visits. OCO observed and received reports of:

- Inconsistent staff instructions during fights, with youth being told to "sit down" in some instances and return to their rooms in others.

- Risks of secondary involvement due to unclear or delayed direction during active incidents.

These observations support the need for standardized fight response protocols, reinforced through training and supervisory oversight.

Youth Rights, Access, and Basic Needs

Communication and Legal Access

Youth consistently raised concerns about:

- GTL phone system irregularities, including unexplained loss of minutes and lack of rollover, particularly after call recording resumed.

- Difficulty contacting public defenders, attorneys, probation officers, and case managers, sometimes in proximity to court dates.

OCO views reliable communication access as a core youth right and recommends continued review and correction of system-level issues impacting phone access.

Clothing, Property, and Personal Items

Across the quarter, OCO documented repeated issues involving:

- Youth lacking adequate clothing, including damaged shoes, missing sweatshirts, torn thermals, and insufficient blankets.

- Delays or gaps in property issuance during orientation.

- Reports of missing personal items and unclear property tracking processes.

These concerns were raised repeatedly across units, indicating the need for improved inventory management and accountability.

Education and Programming

Education Services and Access

OCO observations and staff briefings noted:

- Ongoing implementation of restorative practices within the school, including planned circles and teacher training.

- Concerns regarding a youth assigned to a one-to-one youth to staff ratio to provide increased support and supervision not attending school or receiving grade-appropriate instructional materials.

- Environmental issues within educational spaces, including excessive heat, graffiti, and cleanliness concerns.

While classroom expansions and new programming spaces were viewed positively, OCO emphasized the importance of consistent instructional access for all youth, regardless of housing or supervision status.

Programming and Engagement

Despite challenges, Q2 visits also documented positive practices, including:

- Holiday and Spirit Week activities designed to maintain morale.
- 80% Club participation, arts-based activities, and gingerbread-building projects.
- Weekend engagement strategies, including structured activities and incentives, which staff reported helped reduce idle time and escalation.

Youth frequently requested additional programming, phone minutes, and constructive activities, reflecting a continued need for expansion of skill-building opportunities.

Religious Practice, Identity, and Cultural Considerations

A significant number of youth at BCJJC identified as Muslim during Q2. OCO observed:

- Increased requests for Muslim religious items such as kufis, prayer rugs, and Qur'ans.
- Lack of Muslim services and guidance provided by a qualified Iman.

OCO recommended the development of clear, facility-wide protocols for religious items and the exploration of consistent, qualified chaplain or Imam support to ensure faith practices are supported appropriately and safely.

Staff Morale, Culture, and Professional Conduct

OCO observed a facility culture marked by:

- Staff fatigue and morale challenges, particularly related to staffing shortages, and excessive overtime demands.
- Instances of unprofessional conduct, including staff venting frustrations, using profanity, or expressing dissatisfaction in the presence of youth.
- Leadership acknowledgment of historical culture challenges and efforts to reinforce standards of conduct.

OCO encouraged continued investment in staff coaching, accountability, and leadership engagement, emphasizing that staff professionalism directly impacts youth safety and unit climate.

Key Findings and Recommendations

During Q2 2025, BCJJC demonstrated:

- Persistent physical plant and environmental health deficiencies, including rodent activity, plumbing failures, and sanitation concerns.
- Ongoing operational inconsistencies related to safety, medical communication, water access, and fight response.
- Repeated youth rights concerns involving communication access, clothing, property, and legal contact.
- Notable positive efforts in programming, staff engagement, and restorative initiatives, though unevenly implemented.

OCO acknowledges the dedication of many BCJJC staff and leaders who continue to work under challenging conditions. However, the issues identified during Q2 2025 reflect the need for sustained, coordinated action to ensure the facility consistently meets standards of safety, dignity, legality, and rehabilitative care for all youth.

Core Recommendations

- Prioritize systemic remediation of environmental health and infrastructure issues, including pest control, plumbing, and sewage response.
- Establish clear, written policies for water access, medical communication, and fight response, with consistent staff training.
- Expedite upgrades to medical equipment, documentation systems, and security barriers.
- Strengthen property, clothing, and inventory management processes.
- Review and correct phone system irregularities affecting youth communication.
- Expand structured programming and educational access, including for any youth on one-on-one or restricted status.
- Formalize religious practice protocols and pursue qualified faith-based support.
- Continue addressing staff morale and professionalism through leadership engagement and accountability.

OCO will continue to monitor BCJJC closely and will follow up on the concerns and recommendations outlined in this report during future site visits and reporting periods.

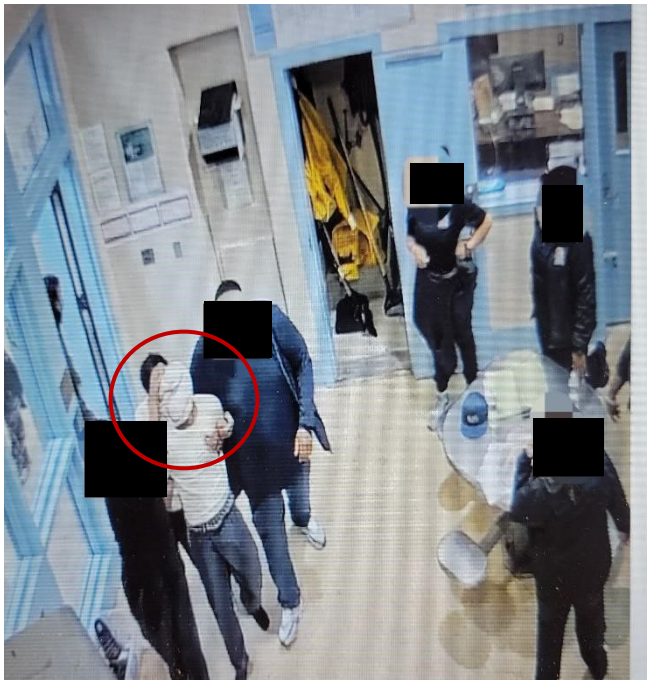
USE OF FORCE AND HIGH-RISK RESTRAINT PRACTICES

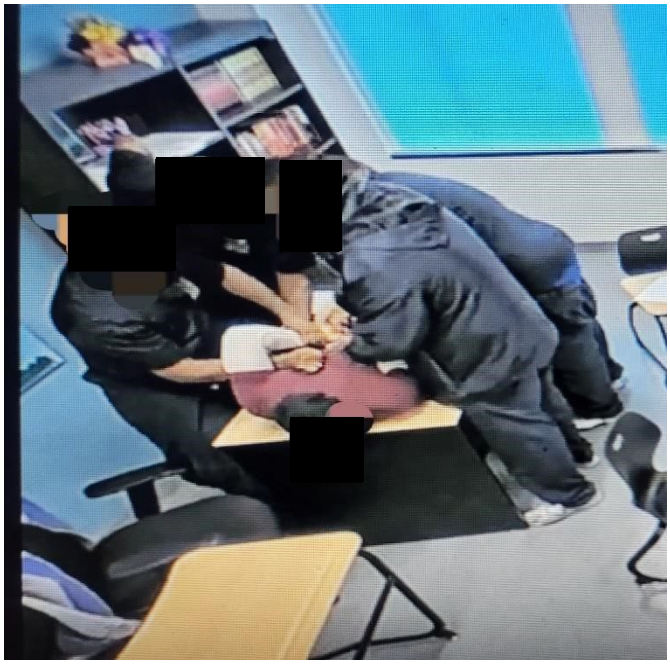
During Q2, the Office of the Correctional Ombudsman identified serious safety concerns related to staff restraint practices at BCJJC, supported by still images obtained from incident reports 186491 and 18640.

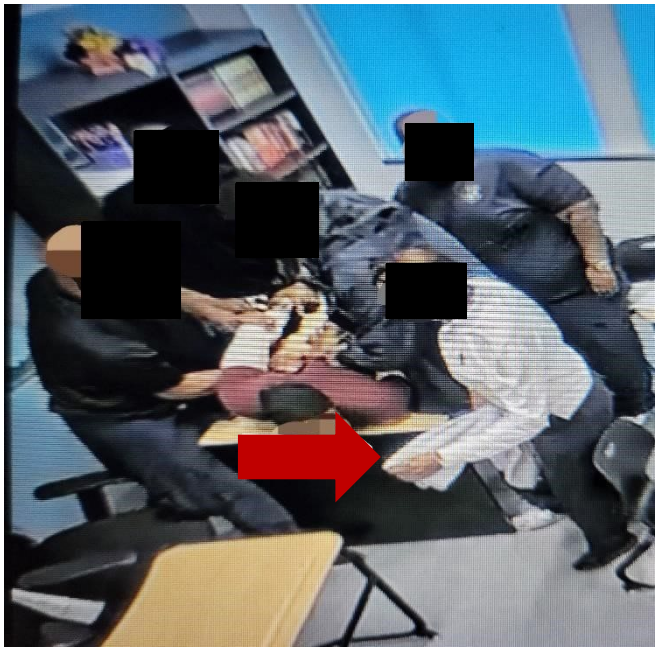
Summary of Concern

- Still shots from 186491 and 18640 appear to show staff placing a tee-shirt or sweatshirt over a youth’s face and mouth during a restraint, rather than utilizing an approved spit mask or employing alternative de-escalation strategies.
- Covering a youth’s face in this manner presents a serious risk of restricted breathing and potential asphyxiation, creating a life-threatening situation.

- This practice is inconsistent with Safe Crisis Management (SCM) principles and conflicts with the requirement that staff use least restrictive and safety-focused interventions.







Policy and Practice Implications

The actions depicted appear to fall outside of DJS-approved restraint protocols and raise questions about staff training, supervisory oversight, and post-incident review processes.

Based on the available documentation, OCO has not yet received confirmation regarding:

- What specific restraint technique staff believed they were using
- Whether the actions were reviewed by supervisors for policy compliance
- Whether corrective action, retraining, or discipline occurred
- Whether BCJJC or DJS leadership formally identified a policy violation or use of force concern

Oversight Action

- OCO leadership has initiated internal review discussions and intends to further examine these incidents as part of broader use of force analysis and staff training needs.
- These concerns have been elevated due to the potential lethality of the restraint method observed and the implications for youth safety.

Recommendations

- Immediate prohibition and reinforcement that clothing or fabric may never be used to cover a youth's face during restraint.
- Mandatory refresher training for all BCJJC staff on SCM-approved restraint techniques and the use of spit masks.
- Formal supervisory and administrative review of 186491 and 18640 to determine compliance, accountability, and corrective actions.
- Enhanced documentation and review protocols for any restraint involving the head, neck, or airway.
- Facility-wide communication reaffirming expectations related to least restrictive interventions and youth medical safety.

Additional Pattern of Escalatory Force – IR 182924 (FY 2025 Q3 & Q4)

In addition to the concerns raised in IR 186491 and IR 18640, OCO notes that similar use of force concerns were previously documented in the FY 2025 Third and Fourth Quarter Report regarding Incident Report 182924 at BCJJC, further indicating a pattern of escalatory intervention practices.

Summary of Video Observations – IR 182924

Video footage reviewed in connection with IR 182924 reflects the following sequence:

- An RA staff member is observed removing a sweatshirt from a youth's shoulders and throwing it into the air.
- The youth then approached the staff member but did not make physical contact.
- The staff member pushed the youth in the upper body after the youth entered the staff member's personal space.
- The staff member then lifted the youth and flipped him through the air onto the floor, landing on top of the youth.
- A supervisor appeared to attempt to direct the staff member to disengage and leave the area while another staff member counseled the youth.
- The involved staff member initially remained in the area and did not immediately comply with supervisory direction.

Based on the video review, the level of force deployed appeared disproportionate to the behavior observed and raised concerns regarding escalation rather than de-escalation in accordance with Safe Crisis Management (SCM) principles.

Subsequent Criminal Proceedings

Following this incident, the involved staff member was indicted (see: https://www.stattorney.org/media-center/press-releases/3241-corrections-officer-indictedfor-alleged-assault-of-a-juvenile) on charges including:

- Second Degree Assault (CR 3-203)
- Misconduct in Office (Common Law)
- Making False Entries in a Public Record (CR 8-606)

The indictment alleges unlawful assault of a juvenile while acting under color of official authority and submission of a false report regarding the physical contact.

While criminal proceedings remain separate from OCO's administrative oversight function and the presumption of innocence applies, the indictment underscores the seriousness of the use of force concerns previously identified during oversight review.

Persistent Safety and Oversight Implications

When IR 182924 is considered alongside:

- IR 186491 and IR 18640 (use of clothing covering the youth's face during restraint, presenting airway risk),
- Questions regarding supervisory review and corrective action,
- And the absence of documented confirmation of retraining or policy reinforcement,

These incidents collectively reflect ongoing concerns related to:

- Escalatory force responses,
- Deviation from least-restrictive intervention standards,
- Supervisory authority and compliance,
- Accuracy and integrity of incident documentation,
- And the adequacy of post-incident administrative review.

These matters do not appear isolated. Instead, they suggest a need for deeper facility-wide evaluation of use of force practices, supervisory culture, and adherence to SCM-approved interventions.

Expanded Recommendations (In Addition to Prior Recommendations)

In light of both the face-covering restraint concerns and IR 182924, OCO recommends:

- A comprehensive review of all BCJJC use of force incidents within FY 2025–FY 2026 to identify patterns of escalation.
- Cross-comparison of written reports against video footage to assess documentation accuracy.
- Formal review of supervisory response when escalation occurs.
- Targeted retraining of staff on de-escalation protocols and proportional force standards.
- Implementation of an early intervention tracking mechanism for staff involved in repeated force incidents.
- Reinforcement of policy prohibiting airway obstruction and ensuring immediate supervisory compliance during incidents.

ONGOING AND UN-ADDRESSED ENVIRONMENTAL HEALTH CONCERNS

Environmental Health & Rodent Infestation (Significant Q2 Oversight Concern – BCJJC)

During Q2 oversight activities OCO identified persistent and escalating rodent activity throughout BCJJC. What initially appeared to be isolated sightings evolved over successive site visits into conditions consistent with an active infestation, raising serious concerns related to youth and staff health, sanitation, and overall facility habitability.

Documented Observations & Reports October 22, 2025

- Staff reported rodents being observed in the kitchen area, a particularly concerning location given food storage and preparation.
- Extermination services were reported to be occurring once per month, though leadership indicated funding had recently been approved to temporarily increase service to twice per month for three months.
- OCO requested that the finalized extermination schedule be shared to ensure staff awareness and accountability.

November 14, 2025

Youth across multiple units independently reported:

- Mice running inside rooms at night
- Mice traveling up stairwells
- Staff confirmed extermination services had been contacted.
- A mouse trap was observed under the stairs.
- Recommendation was made for increased pest-control intervention, as conditions appeared to exceed normal incidental sightings.

November 20, 2025

- Additional mouse traps observed under stairwells, indicating continued rodent presence despite prior intervention.

December 4, 2025

Rodent activity remained ongoing and intensified in severity:

- OCO observed a youth using books and a blanket to block the bottom of his door in an attempt to prevent mice from entering his room.
- Staff reported having to work with their feet elevated to avoid rodents running across them during overnight shifts.

Leadership reported:

- Pest control vendors had been changed.
- Discussions were ongoing to increase service frequency (e.g., from monthly to bi-weekly), pending budget approval.

OCO emphasized that:

- The situation appeared consistent with an infestation, not isolated incidents.
- Comparable conditions in private housing, restaurants, or licensed facilities particularly where food is present would likely trigger immediate code enforcement action.
- OCO formally advised that this issue be elevated and that procurement and budget approvals for enhanced pest control be expedited.

December 11, 2025

- Mouse traps were again observed on units.
- Peanut butter had reportedly been used as bait; OCO noted that alternative pest-control strategies may be more appropriate given the persistence of activity.

December 19, 2025

- Unit 21 continued to report mouse sightings.
- Unit 23 reported no recent sightings, suggesting extermination efforts may be effective in some areas.
- OCO noted the lack of consistency across units and emphasized the need for a facility-wide, coordinated approach.

Youth Safety & Health Implications

Youth reported extreme measures taken in response to rodent presence, including:

- Blocking vents and doors with books, towels, and blankets

Reports from at least two youth stating they had to kill rodents themselves. If accurate, this raises serious concerns regarding:

- Potential exposure to disease
- Lack of protective equipment
- Youth being placed in unsafe and unsanitary living conditions

Oversight Analysis

Based on repeated observations, staff confirmations, photographic evidence, and consistent youth reports across multiple months and units, OCO concludes:

- The rodent issue at BCJJC during Q2 constitutes an ongoing infestation, not isolated activity.
- Existing pest-control efforts have been insufficient in frequency, scope, or effectiveness.
- Environmental conditions have required youth and staff to adopt self-protective measures, which is unacceptable in a secure custodial setting.
- Delays tied to procurement or budget approval have prolonged exposure to unsafe conditions.

Oversight Recommendations (Urgent)

OCO recommends the following actions be taken without delay:

- Immediate escalation of pest-control services to a minimum bi-weekly schedule facility-wide.
- Development of a documented extermination plan, including treatment locations, frequency, and follow-up inspections.
- Clear communication of extermination schedules to staff and leadership.
- Prohibition of youth involvement in pest mitigation (e.g., killing rodents).
- Environmental sealing of entry points, including vents, doors, stairwells, and food storage areas.
- Ongoing monitoring with unit-level reporting to ensure consistent results across the facility.

OCO will continue to monitor this issue closely and considers resolution of the rodent infestation at BCJJC a priority health and safety matter.

Charles Hickey School

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-JrSchool.aspx
Average Daily Pop: Oct-Dec 2025 (FY26Q2)	61 Youth (35 Youth Charged as Adults; 26 Juvenile-Detained)

Program Overview

During the reporting period, OCO observed concerns related to delayed placement processing, resulting in a youth remaining at the facility longer than necessary. There were also concerns regarding physical plant conditions, medical responsiveness, and access to outerwear during cold weather in addition to ongoing and long-standing issues regarding food services. On a positive note, Hickey administrators continued to provide robust programming and family engagement opportunities for young people.

Delayed Treatment Services

- OCO identified a youth with court-ordered treatment needs related to inappropriate sexual behaviors whose placement to an appropriate treatment program was significantly delayed. During this period, safeguards outlined in evaluations were not consistently implemented, raising safety concerns for both staff and the youth. OCO requested expedited placement once the issue was identified. The youth was subsequently transferred to a treatment program where services are currently being provided without further incident.

Programming and Education

- Charles Hickey School maintains a consistent schedule of programming, school activities, and family engagement opportunities. Youth and families regularly participate in events with advance notice and structured planning.

- Dormitories routinely host incentive-based competitions, with youth earning recognition through certificates, food options, and other rewards. Seasonal decorations and themed activities were observed during Thanksgiving and the winter holiday season.

- OCO observed challenges related to education staffing, including high staff turnover and instances of unprofessional conduct among instructional staff in the presence of youth.

Concerns were also identified regarding teacher assignments outside of certified instructional areas.

Food Services

- OCO identified concerns related to food quality and kitchen operations. Issues included expired or unidentifiable items in refrigeration units, and reports of mold on fruit provided for snacks.

- Youth reported concerns that food was often served cold and that limited alternative options were available. Kitchen staffing shortages were reported, particularly during weekends and staff absences.

- Dietary staff raised concerns regarding supervisory communication and workplace climate. Facility leadership responded by implementing mandatory conflict resolution training for staff and supervisors and initiating regular team meetings to address ongoing concerns.

Items without labels:

Medical Services

Youth and direct-care staff reported concerns regarding timeliness of medical responses and communication related to sick call requests. Reports included delayed follow-up and perceptions of disrespectful interactions with medical staff.

Physical Plant

- Youth reported pest concerns, including insects in sleeping areas. OCO observed the facility responded to reported concerns through maintenance and pest control efforts.

- Additional concerns included mold and mildew in shower areas. Following OCO complaints, facility renovations were conducted, including temporary closure of a unit to address medical housing conditions. Youth also reported issues related to cold temperatures in housing units.

Hygiene, Clothing, and Shoes

- Youth reported needs related to clothing and footwear, including coats, shoes, hats, and gloves. OCO observed facility leadership generally addressed these concerns as they were identified. Some youth were observed wearing damaged footwear or insufficient outerwear during cold weather conditions.

- Youth reported concerns regarding being required to move between campus locations during very cold weather conditions without adequate outerwear. During a visit, OCO observed the facility had recently issued new coats to replace older and worn-out outerwear.

Recommendations

- Ensure timely placement processing and adherence to court ordered evaluations and treatment recommendations

- Improve communication and documentation related to youth safety precautions

- Conduct ongoing conflict resolution and supervisory training

- Improve kitchen sanitation, food quality oversight, and staffing levels

- Ensure educational staff are appropriately certified and supported

- Maintain consistent pest control and environmental monitoring

Cheltenham Youth Detention Center

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-youthdetentioncenter.aspx
Average Daily Pop: Oct-Dec 2025 (FY26Q2)	62 Youth (22 Youth Charged as Adults; 41 Juvenile-Detained)

Program Overview

During the quarter, Cheltenham experienced higher levels of youth aggression and use of seclusion compared to other detention centers. New leadership demonstrated a commitment to improving safety, structure, and programming.

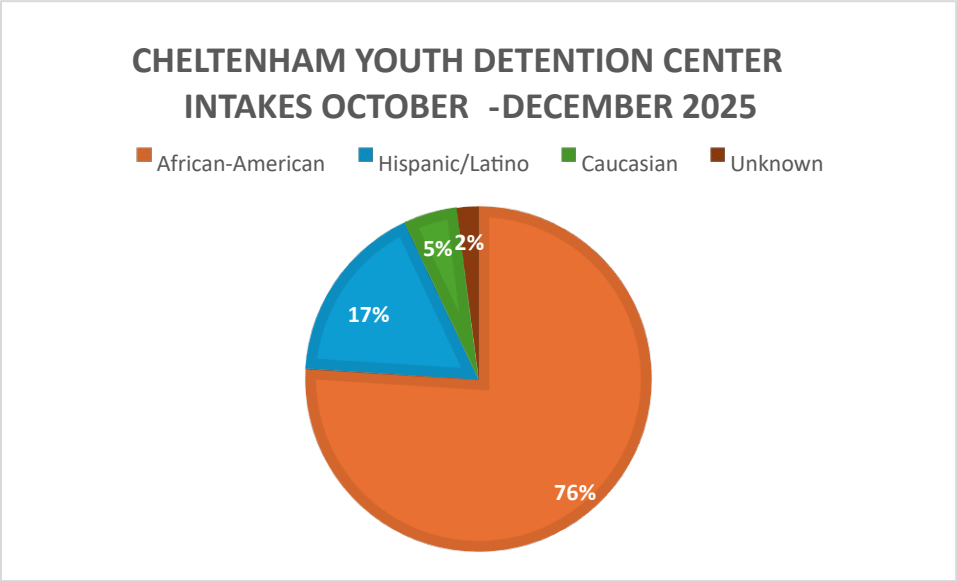
There were also concerns related to staffing shortages, professional conduct, persistent inventory management issues, and equitable access to services and activities for all youth.

DJS detention centers, including Cheltenham, continue to house a significant proportion of youth charged as adults, and youth of color continue to be disproportionately represented in the deep end of the juvenile justice system.

Population

Youth charged as adults accounted for over a third of the detained population (22) on average during the quarter.

Youth of color continue to be disproportionately represented in the deep-end of Maryland's juvenile justice system and made up the majority of intakes during the quarter.



Exposure to Violence and Incident Trends

Detention environments inherently expose youth to violence and the risk of physical harm. During the quarter, several incidents occurred at CYDC in which youths sustained serious medical injuries requiring outside emergency care following assaults by another youth or groups of youth. Injuries included jaw, head, and neck traumas, traumas to the eyes causing swelling and vision issues, and a fractured wrist (Incidents 186105/186106, 186278, 186557, and 186704).

Incidents of youth fights and assaults and use of seclusion were higher at CYDC compared to the Department's other two large detention centers during the quarter.

Facility	ADP: Oct-Dec 2025	Youth on Youth Fights and Assaults	Seclusion
BCJJC	70	40	15
CYDC	62	55	39
Hickey	61	41	7

A superintendent new to a facility leadership role was appointed January 2025 and has communicated a commitment in reducing incidents numbers through improved supervision, structure, and positive programming, as well as increased use of restorative practices, deescalation techniques, and, only as a last resort, physical interventions to prevent fights and assaults from occurring. The superintendent is supported by a newly appointed assistant superintendent overseeing support services who is hands-on and regularly engaged with young people, provides direct support to staff, and shares the vision of creating a safe environment that

is responsive to youth needs. Additional mentorship and support from experienced DJS leadership could further strengthen the administration team at CYDC.

Seclusion

In addition to seclusion incidents recorded in the Department's incident database, young people at CYDC were also placed in seclusion due to staffing shortages. The Department currently only records seclusions in response to a crisis incident in their incident database. Seclusions that occur because of staffing issues are not systematically tracked, and youth in seclusion because of staffing shortages are not afforded the same protections as youth placed in seclusion in response to crisis situations. These safeguards include documentation and completion of observations forms while youth are in seclusion, ten-minute check-ins by direct-care staff, and periodic review by supervisory, medical, and mental health staff.

In Incident 186716, one staff member was assigned to supervise a unit of ten youth on a Sunday in December. The staffer did not let youth out of their cells until later afternoon, around 4 pm after an additional staff arrived on the unit to provide coverage. Later that evening, several youth refused to lock-in for showers and began running around the unit, jumping on desks, and throwing chairs and trash cans. The disruption continued for more than half an hour before youth were escorted back to their cells.

When discussing this incident with the Assistant Ombudsman, the youth reported that staffing shortages had been ongoing on the unit throughout the week and were particularly severe on the weekends. Youth described feeling frustrated and agitated after being confined to their cells for most of the day.

Professional Conduct

CYDC would benefit from a comprehensive approach to addressing staff professional conduct.

In Incident 186705, a youth took some papers from a unit logbook. The staffer on the unit responded by entering his cell and disrupting his personal belongings, chasing the youth around the dayroom, throwing a milk bottle and remote control at him, and knocking a staff phone off a shelf in frustration. Staff assistance was required to escort the staffer off the unit. Although the youth was not acting aggressively, CYDC staff locked the youth in his cell for a "cool down period".

During an internal DJS investigation into the incident, the staffer involved reported working a 15 hour shift the previous day and further reported that when they arrived early for their shift the next day (the day of the incident), the young people were locked in their cells until late morning hours due to staffing shortages. The staffer was also experiencing a personal crisis at home.

In Incident 186652, two staff argued with each other on the unit in front of the young people. Their argument escalated to the point that staff assistance was required to physically separate them.

Burnout significantly increases the risk of unprofessional conduct. Addressing professional conduct issues requires a holistic approach that includes targeted and hands-on training,

consistent staff accountability measures, employment wellness support, and stabilized staffing levels to reduce excessive overtime. Without these measures, lapses in supervision, poor decision-making, and strained youth–staff interactions are likely to persist.

Supplies, Hygiene Products, and Clothes

Inventory maintenance and distribution remain persistent concerns at CYDC. Direct-care staff frequently report not having adequate supplies to maintain unit cleanliness or meet basic youth needs. Cleaning supplies, laundry detergent, toilet paper, and youth hygiene items were not consistently stocked or organized on the units, and the process to obtain replacement supplies was unclear. Direct-care staff reported that management was often unresponsive to unit-level needs.

There were delays in ordering and distributing thermal clothing, and youth reported being cold throughout much of the quarter until the thermals were finally distributed in mid-December. Shoes are not consistently replaced when they become worn, and unlike other facilities, CYDC does not have a pair of higher quality shoes reserved for access and use during recreation time. As a result, youth shoes deteriorate more quickly.

Leisure items such as TVs, gaming systems, and radios, often remain broken for months, leaving youth with limited outlets to manage boredom. Items such as MP3 players which are provided to youth to help them cope and pass time are not adequately stocked and distribution is inconsistent. As a result, some youth receive players while others do not have access which creates tension among youth and leads to theft of players and conflict.

Activities and Events

CYDC leadership and staff offered several programming events for families and young people during the quarter and hosted activities for young people from other facilities. Because girls in Maryland's juvenile justice system are detained in smaller detention facilities which lack outdoor and recreation space, CYDC organized opportunities for detained girls to participate in activities at the facility including a horseback riding event over Veteran's Day held in the large outdoor field at the back of the facility and a December skating party held in the full-sized gym. Girls who attended reported a positive experience and expressed interest in participating in similar events in the future.

Other programming offered during the quarter included:

- Monthly family engagement events such as family feud, family vision board activity, holiday card making, and family engagement dinners for Thanksgiving and Christmas
- Unit versus unit sports tournaments
- Mentorship from a local Christian organization (Comparable faith-based programming was not available for Muslim youth. The facility should work to expand partnerships with

community-based organizations to ensure equitable access to religious services, instruction, and mentorship for youth of different faiths.)

- Halloween-themed games and events
- Ice cream socials
- Breast cancer awareness poster contest
- Unit holiday decoration contest
- Occasional access to the music studio

The facility should ensure that young people housed on the infirmary have access to programming and services available to the general population as youth frequently reported feeling overlooked and forgotten while housed there.

Recommendations

- Expand leadership mentorship and support for new facility administrators to promote effective incident reduction strategies (including decreasing reliance on seclusion), staff accountability, and consistent facility operations aligned with best practices at other facilities
- Implement systemwide tracking and documentation of all seclusions, including those related to staffing shortages, and ensure youth placed in seclusion receive required safeguards and monitoring.
- Improve inventory management systems to ensure timely access to hygiene products, clothing, cleaning supplies, and leisure items on all units.
- Ensure youth housed on the infirmary have consistent access to education, programming, and recreation comparable to youth in the general population.
- Enhance staff training, accountability, and wellness support while continuing to reduce excessive overtime to address burnout and promote professional conduct, appropriate responses to youth behavior, and positive staff–youth interactions.
- Continue to engage youth and families with developmentally appropriate and meaningful programs and events with an emphasis on expanding culturally responsive and inclusive programming to ensure youth of different religious and cultural backgrounds have equitable access to services and mentorship opportunities.

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-EasternShoreChildren-Center.aspx
Average Daily Pop: Oct-Dec 2025 (FY26Q2)	17 Youth (5 Youth Charged as Adults; 12 Juvenile-Detained) (8 Girls; 9 Boys)

Program Overview

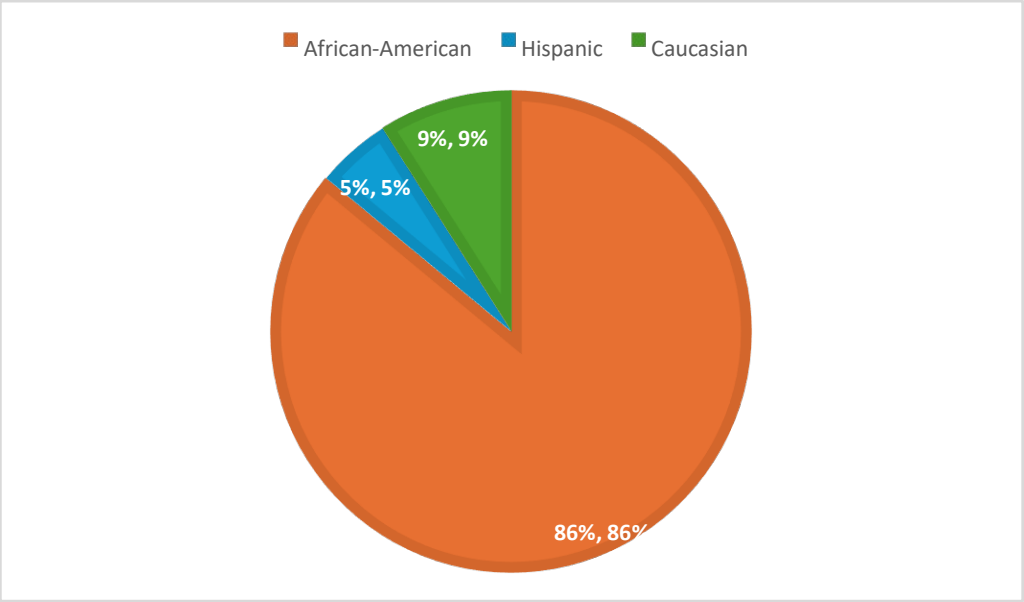
LESCC is a smaller detention facility that under previous leadership had a history of providing a more individualized and supportive milieu. The former superintendent, a highly experienced administrator, emphasized a hands-on, collaborative approach that promoted a stable facility environment that was attentive to youth needs. Vulnerable youth and those with complex behavioral or mental health needs are often transferred to LESCC from other detention centers because of the smaller setting, relative stability, and more responsive care. The facility minimizes the use of potentially traumatizing interventions, including mechanical restraints such as handcuffs and leg irons, which were not used on youth during the quarter.

LESCC is under new leadership, and the new Acting Superintendent will need to embrace a similar management style to maintain the positive facility culture established under prior leadership.

Population

The average daily population at LESCC during the quarter was 17 youth, including 9 boys and 8 girls. The facility had an average daily population of five youth charged as adults during the quarter.

Youth of color continue to be disproportionately represented in the deep end of Maryland's juvenile justice system and accounted for the majority of intakes at LESCC during the quarter.



Activities

In addition to a monthly mentorship program run by a local university, the facility offers consistent in-house Christian services on Thursdays. The superintendent reports ongoing efforts to recruit additional community-based volunteers and organizations to expand programming opportunities.

Facility staff organized multiple holiday activities during the quarter, including Thanksgiving and Christmas family engagement lunches where youth shared a performance for attendees, a holiday cookie-making activity, an ugly sweater contest, sip-and-paint, and bingo. The DJS Headquarters Program team also supported programming by organizing a game day and providing facilities with an activity packet that included ideas and guidance for staff-led programming. Continued follow-up and support by the Program team will be important to ensure that distribution of activity packets results in increased and consistent programming opportunities for young people.

While these efforts are positive, the facility would benefit from an additional recreation specialist to expand programming options. LESCC serves both boys and girls and must provide activities that reflect the interests of both populations. Girls frequently expressed interest in more opportunities for art, creative expression, jewelry making, and spa or makeover days.

A high school graduate participating in a work program within the facility was dependent on the availability of the recreation specialist who oversees the program. The recreation specialist was often pulled to other duties throughout the facility, limiting the time that the youth could participate in work projects. An additional recreation specialist could help address these gaps and better support programming needs.

Education

Educational space at LESCC is limited, creating challenges in accommodating students from three living units. These challenges are compounded by the need to separate students into different groups for security reasons. Unlike larger facilities, LESCC does not have space for a library or media center.

The teaching staff at LESCC is stable and consists of dedicated, experienced educators with expertise in working with detained youth. Plans to allocate a resource teacher position will further support students and help education staff respond more effectively to individual needs despite space and security limitations.

Education staff have demonstrated creativity in addressing physical plant constraints. A small garden was developed in an outdoor green space adjacent to one classroom, providing students with hands-on enrichment during the school day. Students expressed interest in having more consistent access to this space and reported that time working in the garden helps them reduce stress and improve focus.

Recommendations

- New leadership should work to maintain a stable facility milieu and prioritize individualized care for all youth, and especially for those youth with complex behavioral and mental health needs

- Statewide behavioral health resources, including residential treatment and therapeutic placements, should be expanded to reduce the use of detention for youth with intensive and specialized needs.

- Add an additional recreation specialist to expand structured, developmentally appropriate programming for both girls and boys

- Continue to identify and engage local community partners to enhance programming and enrichment opportunities for youth at LESCC

- Support education staff by continuing to allocate additional instructional resources, including a resource teacher, to help mitigate space and security limitations.

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.maryland.gov/pages/facilities/western-marylandchildrencenter.aspx
Average Daily Pop: Oct-Dec 2025 (FY26Q2)	18 Youth (5 Youth Charged as Adults; 10 Juvenile-Detained; 3 Placement)

Program Overview

During Q2 FY26, conditions at Western Maryland Children's Center (WMCC) raised serious and persistent concerns related to youth safety, staffing stability, trauma-informed care, programming, and institutional accountability. While new leadership demonstrated increased visibility and engagement in daily operations, systemic deficiencies continued to compromise the safety, dignity, and rehabilitative purpose of the facility.

Key concerns identified during this quarter include:

- Recurrent youth-on-staff and youth-on-youth violence
- Critically low staffing and persistent ratio noncompliance
- Improper and prolonged room confinement and movement restrictions
- Failure to deliver consistent recreation, programming, and incentives
- Severe trauma exposure and unmet behavioral health needs
- Ongoing contraband circulation, including items facilitating self-harm
- Repeated self-injurious behaviors with inconsistent clinical follow-up
- Interrupted therapeutic services
- Weak coordination with community, faith-based, and treatment partners
- Diminished youth morale, voice, and engagement

- Repeated PREA-relevant sexual safety incidents

Collectively, these conditions reflect a facility struggling to move away from control-based practices toward a gender-responsive, trauma-informed, and healing-centered model of care.

FACILITY CONTEXT & POPULATION

WMCC serves a small but highly vulnerable population of girls, including:

- Youth detained pending court outcomes
- Youth charged as adults
- Youth placed due to treatment and placement needs

Many youth originate from communities far from the facility, resulting in limited family contact, increased isolation, and compounding trauma.

The facility's transition from an all-boys model to an all-girls detention and placement center occurred without sufficient preparation, training, or resource investment, conditions that continue to negatively affect operations and youth outcomes.

SAFETY, USE OF FORCE, AND INCIDENT RESPONSE

Staff Assaults and Youth Allegations

Multiple serious incidents during Q2 FY26 involved staff assaults during escorts, classroom removal, and unit operations, followed in some cases by allegations against staff.

Required reporting protocols were initiated, including administrative notification, CPS referral when applicable, video review, and staff reassignment pending investigation. However, the frequency of these incidents underscores systemic risk factors:

- Staffing instability and supervision gaps
- High-acuity youth needs
- Limited preventative, trauma-responsive de-escalation capacity

Relevant incident reports include:

- 186406 – Staff assaulted during escort, subsequent youth allegation
- 186411 – Allegation against staff (non-sexual)
- 186130 – Allegation against staff (non-sexual)
- 185925 – Allegation against staff (non-sexual)

- 185845 – Allegation against staff (non-sexual)

Youth-on-Youth Violence

Q2 FY26 included planned, coordinated assaults involving multiple youth, including incidents motivated by perceived "snitching." These incidents reflect:

- Inadequate supervision and threat anticipation
- Weak unit control during transitions and recreation
- Breakdown in peer safety and trust

Staff injuries sustained during these incidents further highlight risks to workforce safety.

STAFFING, SUPERVISION, AND OPERATIONS

Staffing Levels and Ratios

WMCC continued to operate with insufficient staffing, including:

- Staff on medical or light duty due to assaults
- Staff under investigation or no-contact status
- Reliance on on-the-job trainees counted toward staffing ratios
- Supervisors diverted into direct-care coverage

The required 1:6 staff-to-youth ratio was frequently unmet, resulting in:

- Improper movement restrictions
- Youth locked down in rotating "in/out" groups
- Limited access to recreation, education, and treatment services

These practices raise serious concerns regarding policy compliance, youth rights, and safety.

Supervision and Accountability

Staff repeatedly reported raising concerns to facility leadership without timely corrective action including:

- Known contraband remaining on units
- Unsafe supervision and movement practices

- Inconsistent or canceled programming
- Poor supervisory follow through

The absence of accountability mechanisms contributed to staff burnout, low morale, and operational instability.

BEHAVIORAL HEALTH, TRAUMA, AND CLINICAL CARE

Trauma Exposure and Mental Health Needs

Youth at WMCC disclosed severe and complex trauma histories, including:

- Sexual exploitation and trafficking
- Substance use dependency
- Domestic violence
- Family instability
- Prior victimization in secure care

Observed behavioral manifestations included:

- Hypervigilance
- Aggression
- Public nudity and sexualized behavior
- Recurrent self-injury
- Requests for psychiatric hospitalization rooted in environmental distress, not acute clinical need

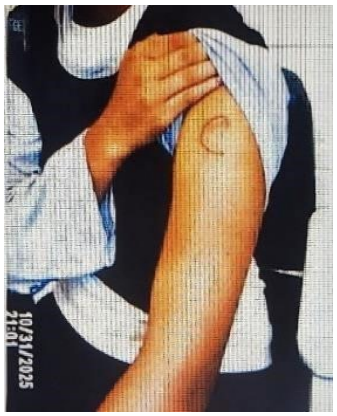
Self-Injurious Behaviors (Pattern Analysis)

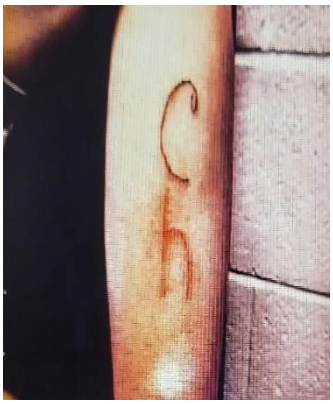
WMCC documented repeated self-injurious behavior incidents during Q2 FY26, including:

- 186810 – Scratching arm to the point of bleeding; clinical intervention required
- 186736 – Self-harm during school following delayed medical response
- 186696 – Wrist cutting; escalation post medical clearance
- 186197 – Self-tattooing observed during shower time

- 186194 – Self-harm disclosed during behavioral health debrief
- 186195 – Admission with untreated physical injuries

  186940 – Classroom escalation and property destruction following delayed bathroom access



Patterns indicate:

- Youth engaging in self-harm to obtain medical attention
- Delayed or inconsistent clinical response
- Lack of sustained post-incident safety planning

Clinical Service Gaps

Significant gaps included:

- Interrupted therapy sessions for operational reasons
- Limited continuity with community-based therapists
- Delayed or absent withdrawal assessments
- Inconsistent wound care and observation following self-harm

These gaps undermine treatment outcomes and may re-traumatize youth.

PROGRAMMING, RECREATION, AND INCENTIVES

Recreation and Activity Deficiencies

WMCC failed to consistently provide:

- Scheduled daily recreation

- Posted and followed 30-day recreation calendars
- Structured facilitated activities

Outdoor recreation was frequently denied due to staffing shortages or discretionary supervisory decisions.

Programming and Engagement

Youth consistently reported boredom and lack of stimulation, noting:

- Activities canceled and not rescheduled
- Minimal enrichment, mentoring, or events
- Incentive based programming lacked meaning

RISE Incentive Store and Commissary

The RISE incentive store was reported as nearly empty with stale, expired or limited inventory. As a result:

- Youth expressed little motivation for RISE incentives
- The behavior management system was effectively neutralized

CONTRABAND AND SELF-HARM RISKS

Contraband control remained a serious concern. Incidents included:

- 186630 – Level II contraband (charging cord found in jacket)
- 186324 – Level II contraband (improvised weapon discovered)

Staff reported prolonged circulation of a vape pen despite administrative notification. Youth also retained access to everyday items facilitating self-harm, despite repeated staff recommendations for safer institutional alternatives.

SEXUAL SAFETY, PREA, AND YOUTH-ON-YOUTH SEXUAL INCIDENTS

WMCC documented multiple PREA relevant incidents during Q2 FY26, including unwanted sexual contact and repeated indecent exposure.

Relevant incidents include:

- 186564 – Youth-on-youth sexual contact allegation (unwanted touching)
- 186493 – Youth-on-youth indecent exposure in classroom
- 186488 – Repeated indecent exposure on housing unit
- 186338 – Youth-on-youth sexual contact observed on camera
- 185995 – Indecent exposure following delayed bathroom access

These incidents occurred in common areas and often escalated despite staff redirection, indicating insufficient supervision, clinical intervention, and prevention strategies. Youth reluctance to use PREA hotlines due to fear of peer retaliation was also documented.

YOUTH VOICE, DIGNITY, AND QUALITY OF LIFE

Youth reported:

- Feeling unsafe and constantly on guard
- Lack of meaningful relationships with staff
- Limited leadership engagement outside of incidents
- Having “nothing to look forward to,” particularly during holidays

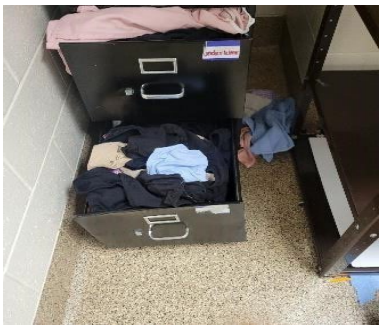
Additional dignity concerns included:

- Damaged clothing
- Unsanitary shower conditions
- Interrupted family and parent-child bonding

These conditions contributed to hopelessness, dysregulation, and resistance to treatment.







RECOMMENDATIONS

Staffing and Supervision

- Stabilize staffing to meet required ratios.
- Prohibit counting trainees toward ratios.
- Strengthen supervisory accountability.
- Ensure consistent application of training models.

Safety and Incident Response

- Enhance proactive supervision during high-risk periods.
- Prohibit unauthorized seclusion practices.
- Ensure proper medical and administrative review after incidents.

Trauma-Informed & Gender-Responsive Care

- Implement facility wide trauma responsive practices.
- Protect uninterrupted therapeutic services.

- Maintain continuity of community-based therapy.
- Ensure immediate withdrawal assessments.

Programming, Recreation, and Incentives

- Reinstate daily recreation with posted calendars.
- Treat outdoor recreation as a requirement.
- Restore a meaningful RISE incentive store.
- Expand structured, mentoring, enrichment, and faith-based programming.

Contraband & Self-Harm Prevention

- Strengthen contraband prevention protocols.
- Replace high risk items with safer alternatives.
- Ensure timely wound care and observation.

Youth Voice & Leadership Engagement

- Increase routine leadership presence.
- Expand youth feedback mechanisms.
- Enhance family engagement and virtual contact.

System-Level Planning

- Reassess WMCC's dual detention/placement role.
- Expand community-based treatment options for girls.
- Align specialized units with their intended purpose.

While leadership changes provide an opportunity for improvement, Q2 FY26 findings demonstrate an urgent need for structural, cultural, and operational reform. Without sustained investment in staffing, trauma-informed care, programming, and accountability, girls at WMCC will continue to experience conditions that fall short of safety, dignity, and rehabilitative intent.

Victor Cullen Center (VCC)

Facility Description:	Hardware-Secure (locked and fenced) Placement for Males
Population Served:	Hardware Secure Committed Youth
Location:	Sabillasville, MD (Frederick County)
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: Oct-Dec 2025 (FY26Q2)	24 Youth

Program Overview

Across Q2, the general atmosphere at VCC was frequently calm, with several positive indicators:

- Respectful youth-staff interactions during many visits
- Well organized graduation ceremonies that reinforced rehabilitation and family engagement
- Youth expressing appreciation for programming when consistently available

However, periods of stability were repeatedly disrupted by systemic vulnerabilities, particularly related to contraband, camera functionality, food safety, environmental controls, and infrastructure reliability.

Contraband Trends & Facility Security

(Significant Q2 Oversight Concern)

Contraband presence particularly vape devices and THC gummies emerged as a persistent, facility-wide concern throughout Q2, with repeated discoveries across multiple cottages, bathrooms, and common areas.

Documented Contraband Incidents

The following incidents illustrate patterns of concealment, access, and movement rather than isolated events:

- IR 186669 (12/10/25):
  K9-assisted search discovered multiple vapes and a bag of gummies hidden in the upper door frame of a bathroom closet on Mitchell Cottage.

- IR 186588 (12/3/25):
  Two electric vapes were found hidden in a maintenance closet inside a youth bathroom on Prettyman Cottage.

- IR 186573 (12/2/25):
  Vape discovered hidden beneath a sink during a directed unit search.

- IR 186568 (12/1/25):
  Vape concealed in a sock hidden inside a toilet paper holder, observed during suspicious youth movement and bathroom usage.

- IR 186257 (11/6/25):
  Vape hidden behind a toilet paper roll following a pattern of staggered bathroom requests.

- IR 186155 (10/29/25):
  Vape pen smuggled onto campus following a home pass, hidden inside a sock concealed in underwear.

- IR 185783 (10/5/25):
  Staff observation of suspicious item exchange during visitation.

Oversight Analysis

These incidents reveal:

- Predictable concealment locations (bathroom fixtures, door frames, maintenance spaces)

- Repeated bathroom based transfer behaviors

- Insufficient environmental controls (unlocked closets, delayed searches)

- Contraband entering via visits, passes, and interior movement

Oversight Conclusion:

Contraband at VCC during Q2 was systemic, not incidental, indicating weaknesses in:

- Search procedures
- Camera coverage reliability
- Environmental security (locked spaces)
- Consistent staff supervision during youth movement

Camera Functionality & Surveillance Gaps

(Critical Safety Concern)

- Site visits confirmed significant numbers of non-functional or mislabeled cameras, creating blind spots in high-risk areas.
- On December 5, 2025, staff confirmed at least 15 cameras were reported as down or unclear in function, including areas adjacent to bathrooms and common spaces where contraband was later recovered.

Oversight Concern:

- Camera outages undermine deterrence
- Incident review becomes unreliable
- Youth and staff safety risks increase substantially

Despite follow-up explanations regarding numbering duplication and lighting conditions, the lack of immediate staff clarity regarding real time camera operability remains a safety concern.

Environmental Safety, Physical Plant Issues & Winter Clothing

Unlocked & Unsecured Areas

Repeated observations included:

- Unlocked janitorial and supply closets
- Maintenance access points inside youth bathrooms
- Inconsistent securing of storage areas

These unsecured areas were later linked to contraband discoveries compounding facility risk.

Sanitation & Plumbing Issues

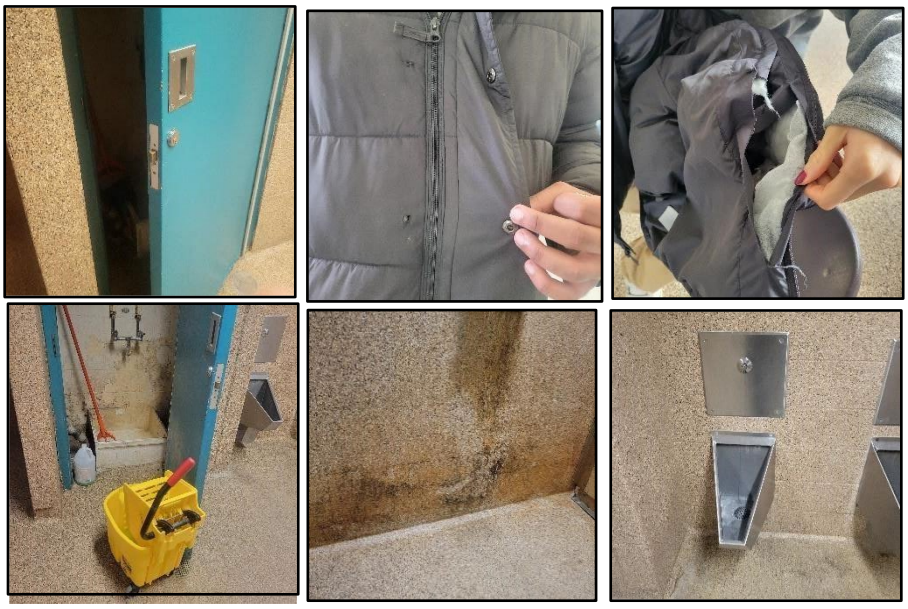
- Shower buildup and discoloration consistent with what appears to be mold or hardened calcium deposits

- Non-flushing urinals
- Maintenance delays requiring outside vendor intervention

Youth Winter Clothing Condition

Across multiple Q2 site visits several youth were observed wearing damaged winter coats including: coats with holes, missing buttons, and compromised insulation.

- The issue was observed repeatedly, not as an isolated occurrence
- Damaged coats were documented during cold weather conditions
- Several youth continued wearing damaged coats across subsequent visits



Oversight Concern:

Inadequate winter clothing presents risks related to:

- Youth health and comfort
- Dignity and humane treatment standards
- Cold weather exposure during campus movement

Food Service, Safety & Nutritional Quality

(Expanded Q2 Concern)

Food Labeling & Compliance

- During the December 18 visit, multiple refrigerated food items lacked required labeling indicating preparation and discard dates, contrary to ServSafe standards and food safety best practices.

Food Quality & Preparation

Youth consistently reported:

- Overcooked and cold meals (documented via photographs)
- Inconsistent preparation of chicken products
- Reduced meal appeal impacting morale and intake

Follow-up review indicated that, during one reporting period, pre-cooked vendor food items were mistakenly prepared using inappropriate cooking methods, resulting in overcooking. Corrective guidance was reportedly provided to kitchen staff regarding proper preparation methods moving forward.

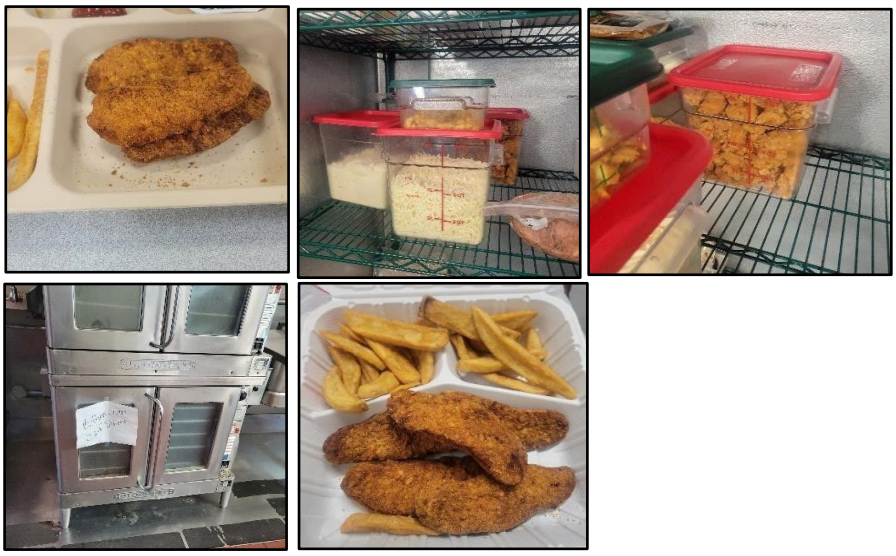
Kitchen Equipment Functionality

- During site visits, a non-operational oven was observed in the facility kitchen.
- Staff indicated the oven had been out of service for an extended period, requiring operational workarounds.

Food Waste Practices

Youth reported routine disposal of unopened and untouched food with no mechanism for redistribution or alternative use raising concerns regarding:

- Government food waste
- Fiscal responsibility
- Nutrition equity



Medical & Dietary Coordination

Dietary Compliance

Instances were documented where youth with medical or dietary restrictions:

- Continued receiving restricted foods
- Experienced delayed clarification of dietary needs

While corrective actions were later reported, initial gaps suggest communication breakdowns between medical, dietary, and custody staff.

Medication Administration

- On at least one visit, a cottage reportedly did not attend scheduled morning medication distribution, requiring administrative follow-up.

Programming, Engagement & Long-Term Youth Planning

Programming Gaps

- YOLO work program pauses created noticeable engagement voids
- Limited alternatives for youth with extended lengths of stay
- Repeated youth requests for expanded vocational and educational programming

Studio & Enrichment Access

- Studio remained largely inaccessible due to staffing limitations
- Youth expressed interest in assisting with facilitation but lacked authorization

Behavioral Health & Case Management Continuity

Youth reported:

- Disruptions following staffing reassignments
- Loss of established therapeutic rapport
- Confusion regarding continuity of services

While administrative explanations were provided, the impact on youth stability and trust remained evident and requires mitigation planning.

Youth Communication & Ombudsman Access

Several youth reported uncertainty regarding:

- Their right to contact OCO
- Staff understanding or communication of oversight access

OCO reiterated that youth communication with oversight must never be restricted and that staff reminders were necessary.

Religious & Cultural Programming

Youth across multiple cottages consistently expressed interest in:

- Jumu’ah prayer
- Qur’an study
- Faith-based grounding

These practices represent protective factors supporting emotional regulation and stability.

Family Engagement & Visitation Concerns

OCO memorialized parental concerns involving:

- Abrupt termination of visits involving young children

- Unclear visitation expectations
- Emotional distress stemming from inconsistent policy application

These concerns underscore the importance of transparent, humane visitation guidance.

Oversight Assessment

Viewed collectively, Q2 oversight findings reveal interconnected system risks:

- Persistent contraband access and concealment
- Camera and surveillance uncertainty
- Environmental control failures
- Food safety, quality, and equipment concerns
- Damaged winter clothing observed across multiple site visits
- Programming gaps for long-term youth
- Erosion of confidence in grievance and communication systems

Each issue compounds the others, elevating institutional risk and requiring sustained corrective attention.

Recommendations

- Implement a comprehensive contraband prevention strategy, including environmental redesign and camera verification.
- Establish real time camera status accountability for control room staff.
- Reinforce locked area compliance audits across all cottages.
- Conduct food service compliance reviews addressing labeling, preparation, equipment functionality, and waste controls.
- Strengthen medical, dietary, and custody communication protocols.
- Expand structured programming alternatives for youth with extended stays.
- Re-train staff on youth rights and access to the Office of the Correctional Ombudsman.
- Clarify and publish visitation procedures with child-appropriate accommodations.

EXCESSIVE USE OF FORCE AND HIGH-RISK RESTRAINT PRACTICES: Q2 REPORT ADDENDUM

Facility: Victor Cullen Center (VCC)
Incident #: 187079
Date of Incident: January 25, 2026
Classification: Class I Assault – Youth-on-Staff

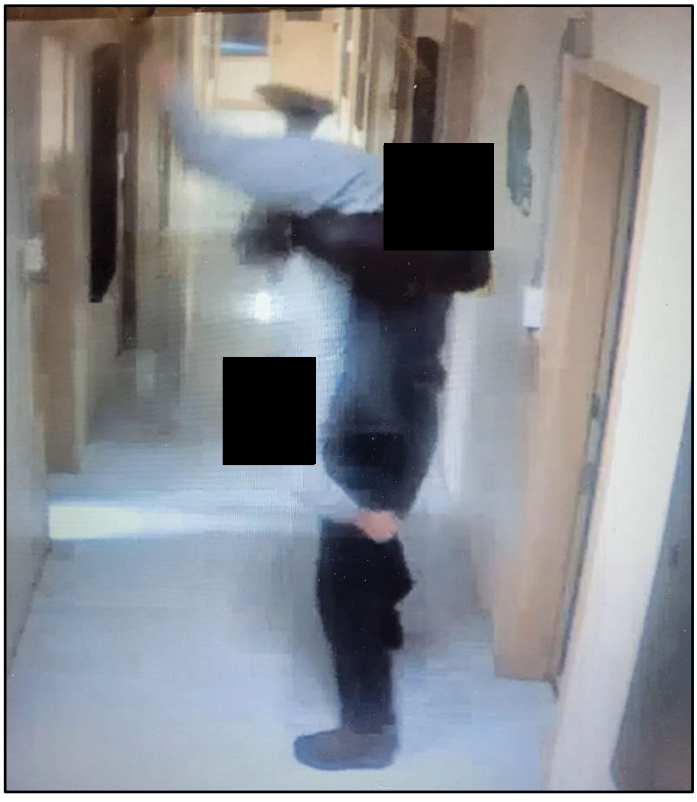
OCO has significant concerns about Incident 187079 because it involves the use of a dangerous and improper restraint that placed the youth at risk of harm, demonstrates a failure to employ appropriate de-escalation strategies, and reveals serious lack of oversight by supervisors and administrators.

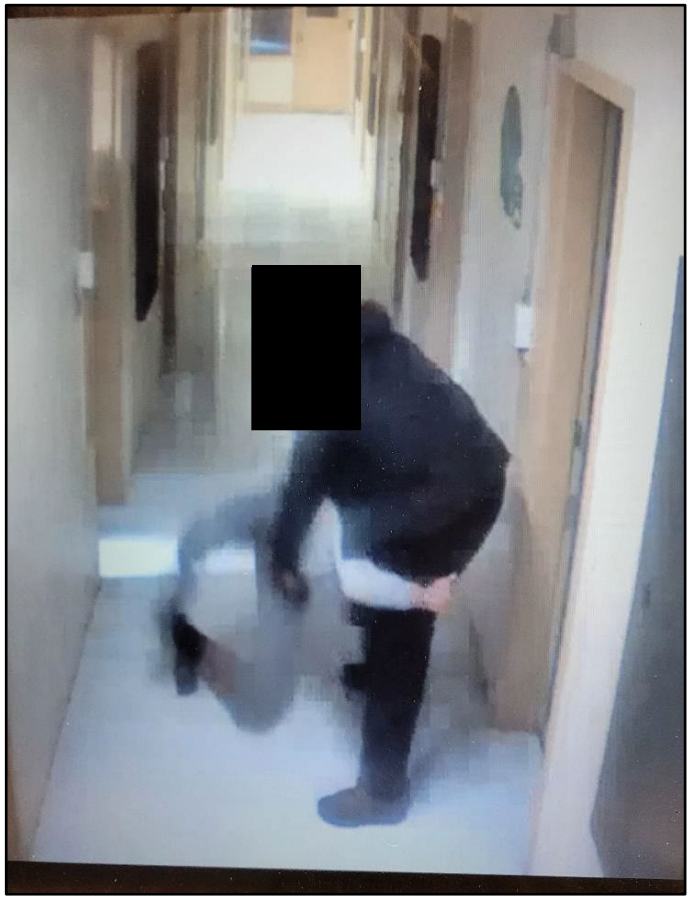
According to the incident report, the precipitating event involved a youth who was upset about not being released from his cell for a bathroom break. The youth was allegedly banging on the door and making verbal threats toward staff. Rather than continuing verbal de-escalation or seeking supervisory support, the responding staff member escalated the encounter.

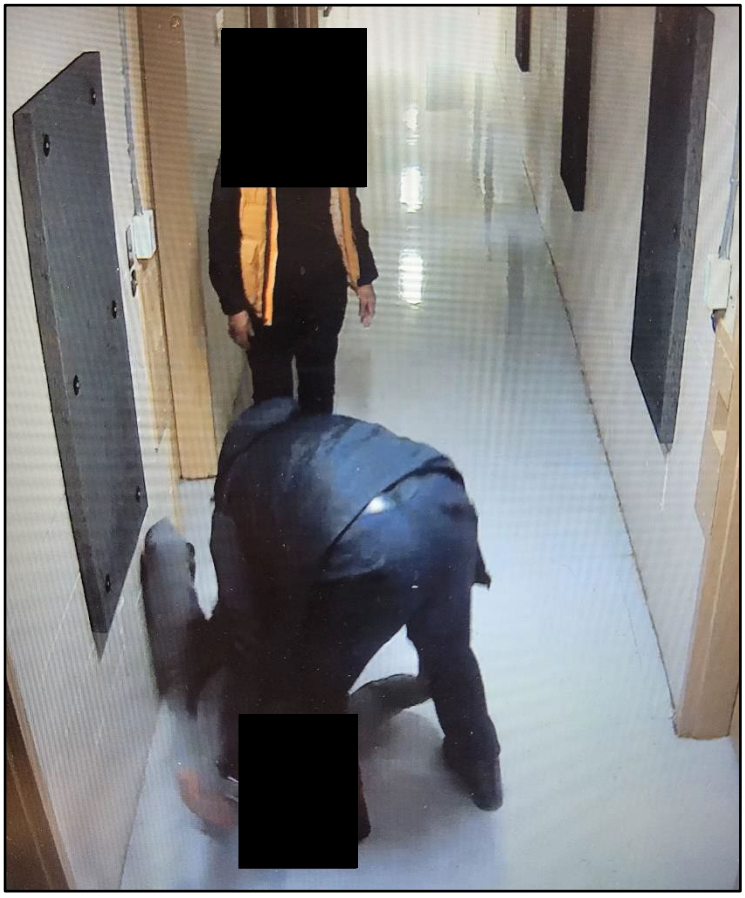
Video Review Findings

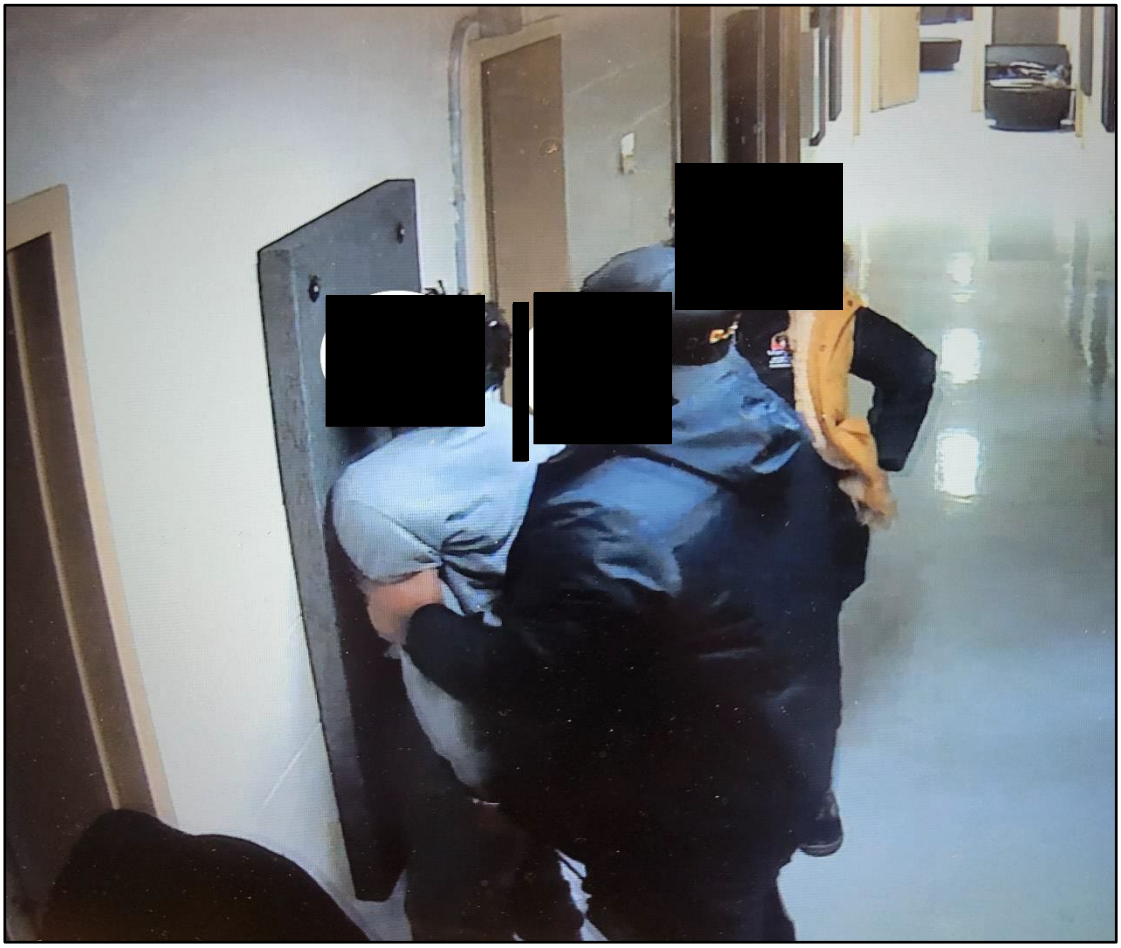
A video review conducted by the Department's internal investigation unit (Office of the Inspector General [OIG]) shows the staff member approaching the youth's door to speak briefly with him. The staff member then unlocked and opened the door, entered the room, and moments later pulled the youth out. The staff member was observed with his right hand around the back of the youth's neck while pulling him into the hallway. He then lifted the youth around the waist, raising him into the air so that the youth's feet were above the staff member's head, before taking him to the floor.









This staffer's actions are inconsistent with approved crisis intervention (SCM) techniques and created a significant risk of injury to the youth's neck, spine, and head.

This positioning raises significant concerns regarding:

- Adherence to Safe Crisis Management (SCM) protocols
- Use of the least restrictive intervention
- Proportionality of force
- Risk of positional injury
- Accuracy and completeness of the written incident report

Use of Force Concerns

Safe Crisis Management (SCM) emphasizes:

- Stabilization over force

- Use of the least restrictive intervention necessary
- Avoidance of high-risk positioning
- Prevention of positional asphyxia
- Preservation of youth dignity

The observable positioning appears inconsistent with core SCM safety principles and warrants immediate supervisory and administrative review.

Inaccurate Staff Account and Documentation Integrity Concern

The involved staff member's written report does not align with what is visible on video. The staffer reported:

"Carefully, the staffer placed the youth in an upper torso restraint to de-escalate his behavior."

This characterization portrays the intervention as measured and consistent with approved technique. Video evidence shows actions that differ significantly from the staffer's description.

OCO has identified discrepancies in multiple cases between written incident narratives and corresponding video evidence.

When written documentation does not accurately reflect observable events, it undermines:

- Transparency
- Accountability
- Oversight reliability
- Agency credibility

OCO will continue monitoring video-to-report consistency across facilities.

Concerns About Witness Response

A second staff member who witnessed the incident was asked whether the proper SCM technique had been used and responded, "I observed the technique, an upper torso." This response demonstrates a misunderstanding of approved restraint practices and underscores the need for stronger training and supervision on de-escalation and restraint methods in addition to staff obligations regarding reporting potential violations of policy.

Lack of Supervisory Critique

The Shift Commander's review likewise did not provide the required critical assessment of the incident. The incident report template specifies that supervisory comments must include a critique of staff actions and whether decisions could have been improved as a learning tool. Instead, the supervisor wrote:

"Staff did a good job intervening. We need to also communicate more as staff with one another strength in numbers. Let's continue to get better, de-escalate, process use our tools and resources."

The comments did not acknowledge the dangerous restraint technique, identify corrective actions, or indicate that the supervisor initiated an incident report alleging staff misconduct or removed the staffer from coverage as required by policy.

Failure to Properly Classify and Document the Incident by Cullen Administration

Although appropriate notifications to Child Protective Services (CPS) and OIG were made after the video was reviewed by Cullen administration, the administration did not enter the matter into the incident database as an allegation of staff misconduct, as required by reporting policy. This failure undermines transparency, limits accountability mechanisms, and restricts the facility's ability to track, review, and correct problematic practices.

Concerns About Facility Culture

Taken together, the above issues reflect more than an isolated reporting error. They indicate a breakdown across multiple levels, including direct care staff, witnesses, and supervisors and administrators, which raises serious concerns about facility culture, expectations for staff conduct, and the day-to-day interactions between staff and youth. Addressing this incident therefore requires not only procedural corrections, but renewed emphasis on de-escalation, accountability, and a facility wide commitment to safe, trauma-informed care.

Recommendations

Immediate Administrative Review

Conduct a formal review of Incident #187079 to determine:

- Whether the restraint technique used was SCM-approved
- Whether the force applied exceeded what was necessary
- Whether supervisory oversight was adequate

- Whether policy violations occurred

Swift and Appropriate Corrective Action

If the review determines that staff utilized unauthorized, excessive, dangerous, or policy prohibited restraint techniques, OCO recommends:

- Swift corrective action
- Appropriate disciplinary consequences consistent with agency policy
- Documentation of findings in personnel records
- Removal from direct youth contact pending investigation, when warranted

Use of unsafe restraint methods must not be normalized or minimized.

Mandatory Re-Certification and Retraining

Require immediate refresher training in:

- Safe Crisis Management (SCM)
- Trauma-Informed Care
- De-escalation techniques
- Positional safety and restraint risks

Training completion should be documented and verified by certified instructors.

90-Day Use of Force Audit

Initiate a structured review of all restraints during the past 90 days to identify:

- Recurring staff involvement
- Escalation trends
- Deviations from SCM standards

Video-to-Report Verification Protocol

Implement a policy requiring supervisors to:

- Review video before approving incident reports
- Ensure written narratives accurately reflect observable actions
- Document any discrepancies and corrective amendments

Reinforcement of Least Restrictive Standards

Reissue formal guidance to all facilities emphasizing:

- Use of least restrictive interventions
- Trauma-informed response practices
- Accountability for deviation from approved restraint techniques

The positioning of a youth elevated and inverted during a restraint event presents serious safety concerns and raises questions regarding compliance with Safe Crisis Management protocols. Accurate reporting and critique of restraint events is critical to ensuring transparency, accountability, and protection of youth in DJS custody.

OCO will continue to monitor restraint practices and documentation integrity across facilities.

Backbone Mountain Youth Center (BMYC)

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/BackboneMountain-Youth-Center.pdf

Average Daily Pop: 21 Youth
Oct-Dec 2025
(FY26Q2)

Program Overview

Overall, BMYC demonstrated periods of stability, constructive staff-youth interactions, and meaningful educational and vocational engagement. At the same time, serious concerns were identified related to use of force practices, restraint supervision, youth safety, and access to educational completion, which warrant continued monitoring and corrective action.

Use of Force and Restraint Practices

Incidents of Concern

OCO reviewed multiple incidents during the reporting period that raise significant concern regarding restraint practices and staff response. Of most concern were Incident Reports 186505 and 186604.

In both incidents, OCO observed:

- A youth being physically lifted and forcefully taken to the ground in a manner consistent with a “suplex-style” takedown
- Multiple staff present without intervening, redirecting, or actively assisting
- Restraint techniques inconsistent with Safe Crisis Management (SCM) principles and the requirement to use the least restrictive intervention

The following still images associated with these incidents. The actions observed represent a significant deviation from approved restraint practices and create an elevated risk of serious injury to youth.

Training and Leadership Response

During the December 10, 2025, site visit:

- Leadership confirmed that supervisors and staff participated in a refresher training on approved restraint techniques Staff were explicitly advised that lifting and forcefully "dumping" a youth is not an approved restraint

- Expectations regarding tapping in, supervisor engagement, and staff accountability during restraints were reinforced

- Facility leadership confirmed that staff involved in the referenced restraint incidents were placed on "no-contact" status pending investigation

OCO notes that while refresher training is an appropriate step, sustained supervision and accountability are necessary to prevent recurrence.

Youth Safety and Basic Needs

Clothing and Weather Preparedness

During December site visits, OCO observed youth wearing attire that was not appropriate for weather conditions, including:

- Youth outdoors wearing slides or slippers

- Youth without coats during school movement

- Youth wearing visibly damaged clothing

Photographs were documented and shared with facility leadership. Leadership responded promptly and indicated that coats and appropriate footwear were available on campus and that youth were reminded to comply with uniform and dress expectations. OCO continues to emphasize that consistent enforcement and supervision are essential to ensure youth safety, particularly during winter months.

Education and Academic Access

Special Education Oversight

OCO reviewed special education documentation for multiple students during the reporting period. Issues identified included:

- Inconsistent documentation of IEP meeting participants
- Clerical inaccuracies within IEP documents
- Need for clarity regarding delivery of special education services while youth are placed at BMYC

Education staff acknowledged these issues and reported corrective actions, including amended documentation and confirmation that progress monitoring occurs on a quarterly basis.

GED Program Access (Significant Concern)

During the November 13, 2025, site visit, OCO was informed of a major change affecting GED testing:

- GED testing was reportedly paused or restricted due to new policy guidance
- Youth who had successfully passed practice tests were unable to complete GED subtests
- At least one youth had passed multiple GED components but was unable to complete the final exam

OCO notes that limiting GED access for eligible youth:

- Disrupts educational continuity and reentry preparation
- Undermines rehabilitation goals
- Risks youth exiting placement without credentials they are academically prepared to earn
- This issue was elevated for further review and remains an area of ongoing oversight.

Programming, Engagement, and Campus Climate

OCO observed several positive developments during Q2:

- Youth participation in college-level coursework
- Youth earning college credits
- Strong performance on MVA learner's permit examinations
- Onsite graduation ceremonies
- Staff assisting youth with resumes and employment preparation
- Continued use of restorative circles
- Expanded opportunities for youth to merge for school and recreation

Across multiple visits, the general campus tone was described as calm, orderly, and constructive, with appropriate staff engagement.

Facilities and Physical Plant

OCO documented:

- Graffiti in cabin bathroom areas
- Disorder in one dayroom
- Odor concerns associated with cleaning equipment
- Pending work orders for flooring and lockers

Photographs were shared with facility leadership. Staff acknowledged these concerns and reported that work orders and corrective actions were in progress. OCO will continue to monitor completion.

Faith-Based and Community Supports

During Q2, youth expressed interest in structured faith-based services, particularly Islamic education and mentorship. OCO supported initial outreach to community partners and monitored coordination with DJS volunteer services staff. OCO continues to observe the need for timely implementation of approved faith-based programming once partnerships are established.

Recommendations

- Strengthen supervision and enforcement of approved SCM restraint practices
- Address staff inaction during restraints as a performance and safety issue
- Ensure youth consistently wear weather appropriate clothing
- Resolve barriers to GED testing and credential completion
- Maintain timely resolution of facility maintenance and cleanliness issues

Summary

Backbone Mountain Youth Center demonstrated positive engagement, programming, and leadership responsiveness during the second quarter of FY26. However, serious concerns related to restraint practices (186505 and 186604) and access to GED completion require continued corrective action and oversight. OCO will maintain focused monitoring of these issues into the next reporting period.

Green Ridge Youth Center (GRYC)

Facility Description:	Staff Secure Placement for Males
Population Served:	Staff Secure Committed Youth
Location:	Flintstone, MD (Allegany County)
Rated Capacity:	18
Operated By:	Owned and Operated by the Maryland Department of Juvenile Services (The Department/DJS) https://djs.maryland.gov/pages/facilities/green-ridgeyouthcenter.aspx
Average Daily Pop: Oct-Dec 2025 (FY26Q2)	15 Youth

Program Overview

During the reporting period, Green Ridge Youth Center operated without a permanent Superintendent or Assistant Superintendent. Acting leadership structures were in place, contributing to challenges related to staff supervision, accountability, and facility culture.

- Youth reported inconsistent staff engagement across shifts, including overly familiar interactions or punitive approaches depending on staff temperament. OCO observed concerns related to a lack of a trauma-informed approach and cultural responsiveness, with youth reporting challenges related to food preparation, perceived lack of empathy, and strained youth-staff relationships.

- A permanent Superintendent was hired and started in February 2026.

Programming and Education

- Youth participated in a range of structured programming and off grounds activities, including recreational outings, family engagement events, academic enrichment opportunities, and service-learning initiatives. These activities served as incentive based programming and positive reinforcement for appropriate behavior.

- Youth participated in academic competitions, college and career readiness events, and family engagement activities. OCO observed improved classroom culture following a site visit, during which concerns related to horseplay and redirection were addressed.

- GRYC maintains a monthly youth advisory meeting in which designated youth representatives meet with administrators to discuss facility issues and provide feedback.

Food Services

- Youth reported concerns regarding food quality, including bland taste, inconsistent preparation, and limited access to condiments or alternative options.

Physical Plant

- OCO identified water damage and pooling in dormitory bathroom areas due to inadequate drainage. Excessive water accumulation created slippery and potentially hazardous conditions requiring daily mitigation.

Hygiene, Clothing, and Shoes

- Some youth were observed not wearing weather appropriate clothing during cold conditions due to fit, comfort, or inability to fasten coats. At OCO's request, the facility addressed clothing and footwear needs.

- Youth had access to professional barber services every two weeks.

Recommendations

- Implement consistent leadership staffing for Superintendent and Assistant Superintendent roles

- Provide recurring training in trauma-informed care

- Improve cultural responsiveness through targeted staff development and include dietary staff on cultural responsiveness training

- Address dormitory drainage and moisture issues to reduce hazards and environmental concerns

- Staff would benefit from implementing daily checks to ensure youth are dressed appropriately for weather conditions.

Morningstar 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
Operated By:	VQ https://www.vq.com/by-state/maryland#morning-star
Average Daily Pop: Oct-Dec 2025 (FY26Q2)	(Current staffing levels can accommodate 10 youth)

Program Overview

Morningstar Youth Academy is a CARF-accredited, DJS-licensed staff secure (not locked or fenced) placement for males, operated by VQ. Morningstar utilizes the trauma-informed Sanctuary Model, which fosters the development of positive youth–staff relationships and promotes a safe and supportive environment. The program leverages community resources to supplement on-site programming. Therapeutic services are provided both on-site and through contracted community providers. Youth regularly participate in off-site recreational, enrichment, religious, and volunteer activities, and eligible youth are encouraged to pursue employment opportunities in the community.

The facility is currently in the process of becoming PREA compliant in response to DJS requirements for licensed placements.

Activities

Morningstar has made a deliberate effort to expand on-site programming through the introduction of after-school clubs developed in partnership with youth and facilitated by facility staff. Club themes are guided by youth and staff interests and include science and outdoor activities, culinary arts, book club, and anime club. These clubs reflect a strength-based approach aligned with positive youth development principles and promote engagement, collaboration, and skill-building.

After-school clubs were supplemented by seasonal on-site activities during the quarter, including an ugly sweater contest, holiday decorating, and Christmas card and ornament-making activities.

On-site programming is further enhanced through community-based outings. During the quarter, youth participated in seasonal activities such as a local history and ghost story walk, trick-or-treating, and a trip to view holiday lights in Ocean City, Maryland. These activities support

prosocial skill development and foster a sense of belonging and connection to the broader community.

Religious Services

Equitable access to Muslim religious services remains an ongoing concern for youth in DJS custody. To better meet the needs of Muslim youth at Morningstar, program administrators established a partnership with a Muslim organization in nearby Easton, Maryland. This partnership has enabled youth to participate in in-person religious services, instruction, and mentorship.

Education Services

Education services at Morningstar are provided through virtual high school classes offered by Dorchester County Public Schools, with an on-site educator available to support students. During the quarter, one youth reported difficulty engaging with the virtual format and struggled to maintain attention and follow course material. In response, the facility increased individualized in-person support and assisted the youth in accessing additional one-on-one support from the virtual teacher.

Population and Incidents

Fourteen youth were placed at Morningstar during the quarter. Three youth were successfully discharged, and three youth were ejected from the program for failure to follow program expectations.

Incidents of aggression remain relatively low at smaller licensed facilities. During the quarter, a newly admitted youth was involved in a fight and an assault (Incidents 186650 and 186626). Following these incidents, the youth was ejected from the program. Staff subsequently facilitated a restorative circle with the remaining youth to process the incidents and repair the facility milieu.

Residential programs continue to grapple with challenges related to contraband. In Incident 186791, a youth returned from a home pass with a vape pen. In Incident 186317, another youth smuggled Suboxone strips onto campus following a home pass, and several youth later tested positive for Suboxone.

Recommendations

- Exposure to consistent and meaningful recreational, enrichment, and volunteer opportunities contributes to positive youth engagement and low rates of aggression. Morningstar should continue to support and expand strength based, trauma-informed programming, including youth-led after-school clubs and community engagement activities.

- Strengthen education supports for students participating in virtual learning by ensuring consistent access to individualized, in-person academic assistance for students who struggle with the virtual format.

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 8 Youth
Operated By:	Building Communities Today for Tomorrow https://bcttworks.com/

Program Overview

One Love is a DJS-licensed residential group home operated by Building Communities Today for Tomorrow, Inc., a Baltimore-based community organization. The home is located in a residential neighborhood in northeast Baltimore City and serves up to eight males ages 16 to 20. Young people from both the Baltimore City Department of Social Services and the Maryland Department of Juvenile Services are placed at the home.

One Love provides a home like and supportive environment. Young people attend local community schools, and those who have earned high school diplomas are able to work in nearby businesses. Residents receive memberships to a local YMCA for recreation, and staff organize weekly outings for enrichment. Therapeutic and medical services are provided by community-based providers.

The program is not highly structured, making One Love best suited for mature, self-motivated young people who can manage a greater level of independence.

During the quarter, four youth were placed at One Love through DJS. Two youths were successfully discharged, and two new intakes arrived in December 2026.

Essential Documents

Youth placed at One Love often arrive from DJS-operated detention and placement centers or licensed and contracted placement programs without essential documents such as birth certificates, state identification cards, Social Security cards, or medical insurance cards. Without these documents, young people face barriers to employment and enrollment in government and community-based services. DJS community case managers should ensure that youth are discharged from programs with the documentation necessary to support successful community reentry.

Education, Career Readiness, and Employment

Education and employment are key pathways to successful reentry, and young people at One Love consistently express interest in pursuing higher education, trades, or employment as steps toward independent living. The group home encourages youth to apply for jobs in nearby businesses. During the quarter, two youth secured part-time and full-time employment at local grocery stores. Over time, however, youth reported frustration with the limited opportunities for advancement in these positions and expressed interest in community college and careers in fields such as cybersecurity, culinary arts, and sales.

Young people at One Love would benefit from more structured and intensive case management and life coaching services focused on connecting them to post-secondary education, workforce development, and employment readiness opportunities. Targeted supports could help youth pursue careers in high-demand fields that offer livable wages and opportunities for long-term growth.

Recommendations

- Strengthen case management services to better support youth in achieving their educational and career goals.

- Ensure youth are discharged from DJS-operated detention centers and placement programs with essential identification and personal documents, including birth certificates, state identification cards, Social Security cards, and medical insurance information, to support employment, education, and successful community reentry.

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) https://djs.maryland.gov/Documents/facilities/Charles-H-Hickey-Jr-Structured-Shelter-Care-Program.pdf

Program Overview

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. Shelter beds should be expanded to accommodate young people on the Department's shelter waiting list.

Programming and Education

Youth attend public school in the local community. The Department has improved enrolling youth in the local schools, however youth awaiting enrollment in community schools were observed sleeping during the school day. The Department should work with JSEP to provide educational services during the day until local youth school enrollment has been completed.

Shelter staff continue to provide daily activities and work with detention recreational staff to provide daily large muscle activities. Shelter Supervisors and staff continue to provide holiday and family events to support youth and their families.

Family Engagement

Family engagement and visitation have increased this reporting period. Shelter case management should consider scheduling individual family sessions with support from the Department's mental health team. Providing this service will support the youth aftercare and home reintegration efforts. OCO commends the Department in their efforts to provide a homelike environment to youth at the Hickey Shelter.

Food Services

Meals for the Shelter program are prepared on grounds and provided by Hickey food services. Youth complained this reporting period that food lack seasoning, is often under cooked and lacks quality. Students complained that the meal portions are small.

The Shelter Program continues to provide incentive snacks which address youth continued hunger complaints.

Recommendations

- Work with JSEP to offer students educational services while they are pending enrollment with Baltimore County schools.

- The Shelter should have a separate operations handbook with approved policies and procedures. A specific handbook should be given to youth and parents.

- The Department should increase capacity to accommodate shelter eligible young people who are on the waiting list for a shelter bed.

- Shelter youth should be engaged in independent living skill development. Mental Health and case management should offer specific skill development groups in the following areas: laundry, hygiene and housekeeping, budget management, use of public transportation, interviewing skills, job readiness and career development groups.