

**Office of the Correctional
Ombudsman
Juvenile Oversight Division
FY 2026
Third Quarter
Report**



THE MARYLAND
OFFICE OF THE
CORRECTIONAL
OMBUDSMAN



"Change Means Growth"

Credit: Backbone Mountain Youth Center

STATE OF MARYLAND OFFICE OF THE CORRECTIONAL OMBUDSMAN

JUVENILE OVERSIGHT DIVISION

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

Secretary of the Department of Juvenile Services, Betsy Fox Tolentino

The Honorable Andre Davis, Chairperson Maryland 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

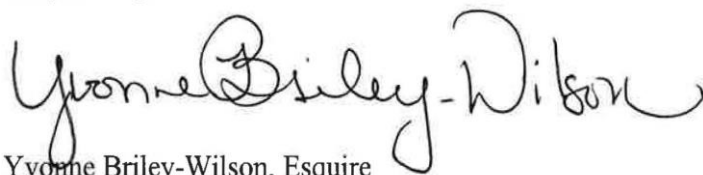
The Office of the Correctional Ombudsman (OCO), Juvenile Oversight Division (JOD), presents this third quarter report for Fiscal Year 2026. OCO reflects on the importance of our work and its impact on the community, the Department of Juvenile Services (DJS), and the youth and families affected by adjudication and detention. We believe that OCO's efforts serve as a link to the state's past and a bridge and pathway to our future.

OCO was privileged to attend the unveiling of a historical roadside marker at the Cheltenham Youth Detention Center in Prince George's County, Maryland, honoring the legacy of the lives lost at the Maryland House of Reformation for Colored Boys. This event acknowledges the unjust and unfair treatment of young African American boys in Maryland during a time when their lives were deemed expendable and insignificant and only significant to their families left home to worry. Historically, this was a period of time when the United States grappled with recognizing the true value of diversity, rehabilitation, and humanity within correctional and juvenile services.

Regrettably, this country is once again facing challenges, controversies, and changes. This momentous occasion symbolized hope and humanity, illustrating the importance of OCO/JOD's work. By establishing the OCO, the Governor, legislators, community partners, and supporters of Senate Bill 134 committed to creating an agency dedicated to improving the lives of those in the care and custody of correctional and DJS facilities in Maryland. They also pledged to ensure that justice-involved individuals have the opportunity to return to our communities rehabilitated and better equipped for productive engagement, thereby reducing recidivism and fostering safer communities in Maryland.

The purpose of this report and all OCO reports is to enhance the essential operations of all DJS and DPSCS facilities, encouraging transparency and accountability. This ensures fairness, dignity, humanity, and respect for those in care and custody, as well as for staff. Shedding light on OCO's observations mitigates the risks associated with ignorance or neglect of concerns, creating opportunities for correction and change. Furthermore, it guarantees that lives are preserved and improved, staff feel supported, and that hopefully we will never repeat the tragic events that occurred at the House of Reformation for Colored Boys.

Respectfully,

A handwritten signature in black ink that reads "Yvonne Briley-Wilson". The signature is written in a cursive, flowing style.

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, DJS-operated placement centers, the DJS-operated shelter care program, and DJS-licensed residential facilities. 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 interactions. 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 <https://oco.maryland.gov/> and at [https://mlsd.ent.sirsi.net/client/en_US/default/search/detailnonmodal/ent:\\$002f\\$002fSD_ILS\\$002f0\\$002fSD_ILS:42350/one](https://mlsd.ent.sirsi.net/client/en_US/default/search/detailnonmodal/ent:$002f$002fSD_ILS$002f0$002fSD_ILS:42350/one)

Throughout FY26, JOD consistently 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 or staff by phone at **(844) OCO-INFO / (844) 626-4636**, or by email at jod.oco@maryland.gov.

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Individual Facility Reports: Detention Centers

Baltimore City Juvenile Justice Center (BCJJC)

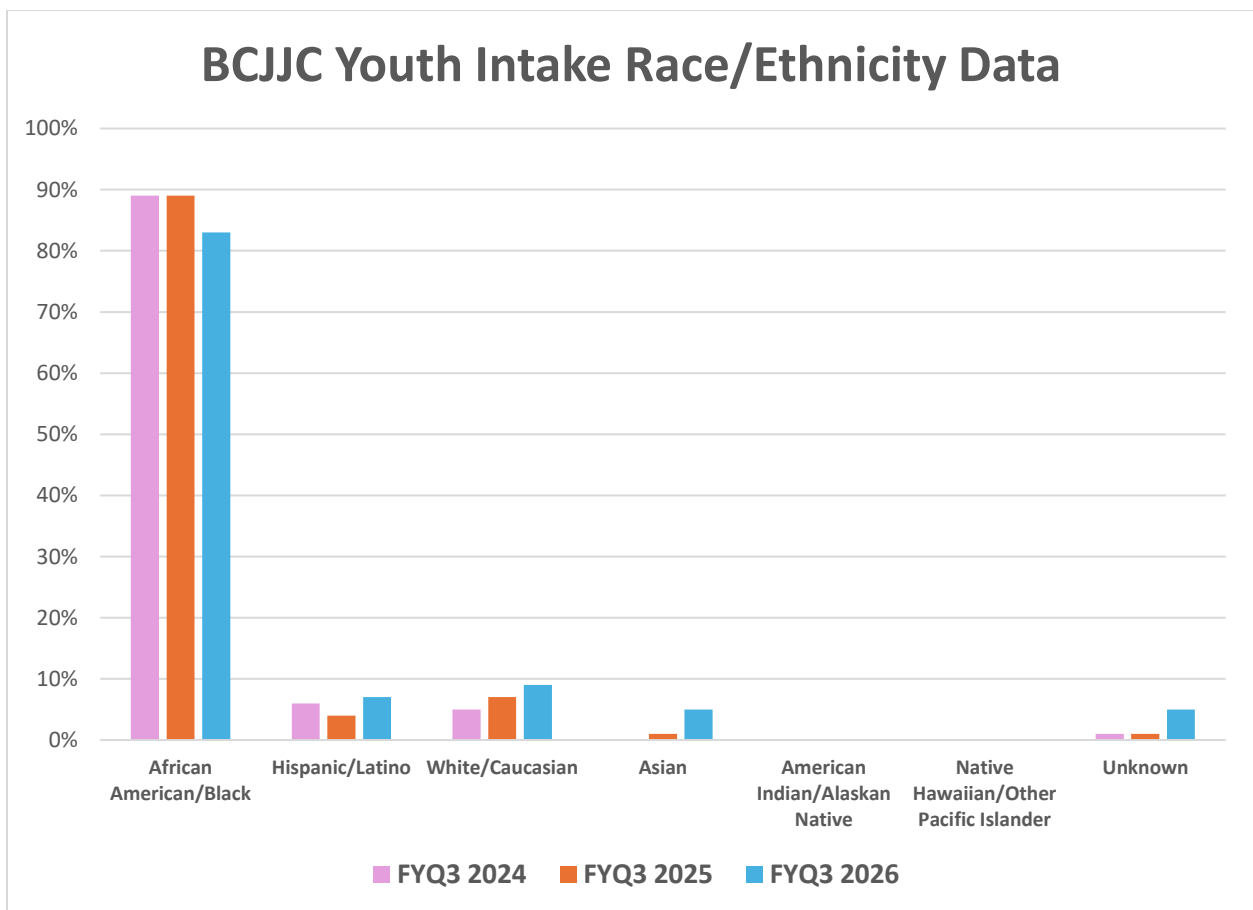
Facility Description: Hardware Secure (locked and fenced) Detention Center for Males
 Population Served: Juvenile-Detained; Youth Charged as Adults; Pending Placement
 Location: Baltimore, MD
 Rated Capacity: 108 Youth
 Operated By: Owned and Operated by the Maryland Department of Juvenile Services (The Department/DJS)
<https://djs.maryland.gov/Pages/facilities/Baltimore-City-Juvenile-Justice-Center.aspx>

BCJJC – Selected Incident Categories	FYQ3 2024	FYQ3 2025	FYQ3 2026
Average Daily Population (ADP)	98	95	72
1. Youth on Youth Assault/Fight	78	107	59
2. Alleged Youth on Staff Assault	3	10	2
3. Physical Restraint	49	100	50
4. Use of Handcuffs and/or Shackles	6	8	3
5. Seclusion	3	5	5
6. Contraband	10	9	5
7. Suicide Ideation	1	4	5
8. Suicide Attempt	0	0	0
9. Self-Injurious Behavior	0	0	0

Information obtained from DJS database

Data Highlights from DJS database

- The facility experienced a decrease in Average Daily Population (ADP) compared to prior years.
- Reported incidents of youth-on-youth assaults and fights decreased compared to FY2025.
- Incidents involving physical restraints decreased from FY2025 levels.
- Alleged youth-on-staff assaults and use of mechanical restraints declined.
- Contraband incidents decreased slightly, though remain present.
- Reported seclusions remained unchanged, indicating continued reliance.
- Suicide ideation increased, signaling elevated behavioral health concerns.



Facility Conditions and Daily Living Environment

At the beginning of the quarter, BCJJC appeared to be operating in a relatively stable condition following weather-related disruptions. Leadership reported no major system failures, and the facility had successfully navigated a period of inclement weather. However, as site visits progressed through January and into February and March, a more complex and concerning picture emerged.

OCO documented a range of ongoing physical plant issues affecting both operations and the daily experience of youth. A malfunctioning medical corridor door could not be opened through Master Control, creating both operational inefficiencies and safety concerns. Intercom systems across certain pods, particularly F-Pod, were not functioning consistently, limiting communication between staff and control areas. These issues were reportedly under repair; however, their impact was evident during site visits.

Shower functionality also presented challenges. On Unit 33, a shower was observed to shut off within seconds, requiring repeated activation to maintain water flow. In another area, a toilet was observed with what appeared to be sewage backup, raising immediate sanitation concerns. Additional issues included broken unit phones, damaged fixtures, and maintenance-related disruptions that affected youth access to basic daily necessities.

Rodent activity remained a persistent concern throughout the quarter. Youth reported seeing mice and described placing barriers under doors to prevent entry. While a new pest control contract has been implemented and service frequency increased, OCO observed exposed traps accessible to youth in violation of intergraded pest management protocol.

Access to water was also inconsistent across units. Youth described varying rules regarding water bottles, and during one walkthrough, a water cooler was observed empty and in need of cleaning. These inconsistencies contributed to concerns regarding equitable access to basic resources.

Youth also raised repeated concerns regarding clothing and personal property. Several youth reported having only one pair of shoes, many of which were visibly damaged or worn. Torn thermals and pants were observed, and youth requested essential items such as headphones and religious materials. While these may appear to be isolated issues, collectively they reflect systemic gaps in ensuring that youth have consistent access to basic needs.

Mouse Trap in Common Area



Clogged Room Toilet



Gang Graffiti in Shower



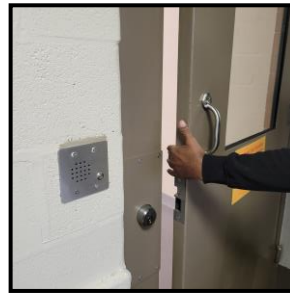
Flooded Room



Unclean Water Cooler



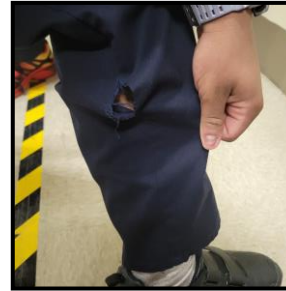
Unsecured Door



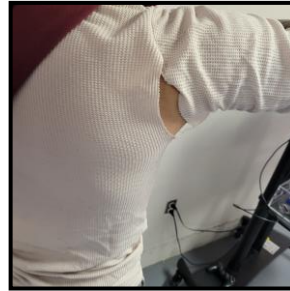
Damaged Shoe



Hole in Pants



Torn Thermal Shirt

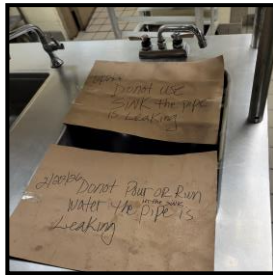


Food Service and Kitchen Operations

Kitchen operations during the quarter reflected both early challenges and later improvements. During January site visits, OCO observed equipment failures, including a freezer that was not operational due to a compressor issue. Additional kitchen equipment including a cooking skillet and garbage disposal was also non-functional. Food safety concerns were identified when opened food items were not labeled or dated, requiring immediate corrective action.

Despite these early concerns, subsequent visits showed improvement. The kitchen was observed to be clean and organized, and staff demonstrated execution of Ramadan meal accommodations. Meals prepared for fasting youth were described as well-coordinated and thoughtfully implemented. These efforts were recognized as a strength within the facility, with the kitchen noted as a potential model for other sites on how Ramadan meals should be prepared.

Garbage Disposal



Cook Skillet



Unlabeled Food



Unlabeled Food



Ramadan Breakfast Box



Safety, Security, and Escalating Incident Activity

Over the course of the quarter, OCO observed a concerning increase in youth-on-youth violence and overall instability within the facility. This escalation was reflected across multiple incident reports and video reviews, including IR #187494, IR #187502, IR #187252, IR #187532, IR #187539, and IR #187772.

A critical incident occurred on March 2nd involving a large-scale altercation between youth from Units 20 and 21 in the facility-based school setting. Video footage associated with IR #187494 depicted a chaotic and rapidly escalating situation in which multiple youth were actively engaged in physical altercations. Staff response was delayed in establishing control; both a staff member and a teacher were reported to have been injured during this incident.

During review of the footage, OCO observed that several responding staff had difficulty distinguishing youth from the two different units. This challenge was compounded by the fact that youth from both units were wearing identical uniform shirts. As staff attempted to regain control, youth were rapidly moved into classrooms without clear identification or separation. As a result, youth involved in the conflict were inadvertently placed together in the same spaces, allowing altercations to continue rather than being contained. This dynamic contributed significantly to the level of chaos observed during the incident.

Additional incidents reviewed during the quarter, including IR #187532 and IR #187539, further reflected patterns of youth-on-youth aggression and operational challenges in managing escalating behavior. The video associated with IR #187772, which captured activity on Unit 41 showed a high level of disorder and lack of control among youth awaiting placement.

Movement protocols during transitions appeared inconsistent, and staff placement did not always allow for effective supervision. Additionally, open radio communication practices may have

contributed to youth awareness of staff movement, potentially enabling coordinated behavior and increasing the likelihood of escalation.

In response to these operational patterns, OCO raised concerns with DJS leadership regarding the increase in violent incidents and the resulting impact on youth and staff safety. OCO formally requested the development of an action plan to address these issues and recommended the use of community-based organizations to support restorative justice interventions and mediation efforts.

Education and Instructional Disruption

The March 2nd incident had a significant impact on the educational environment at BCJJC. Following the altercation, Unit 20 was removed from the main education setting and relocated to an alternative classroom. While this decision was intended to reduce conflict, it resulted in substantial disruption to instruction.

Teachers were required to rotate between locations, and the new classroom setting exposed students to constant hallway traffic and distractions. Reports indicated that students who had previously demonstrated strong academic performance experienced noticeable regression. Instructional time was frequently interrupted for behavioral redirection and emotional support.

Youth who were removed from class due to incidents were not consistently provided with alternative schoolwork. OCO observed youth on housing units during instructional hours without structured educational engagement, raising concerns about continuity of instruction and equitable access to learning.

These disruptions were particularly impactful for youth with special education needs and those requiring structured learning environments.

Programming and Structured Activities

Youth consistently reported limited access to structured programming, particularly during weekends and following major incidents. Observations confirmed that during these periods, youth often relied on unstructured activities such as playing cards or watching television.

While recreational opportunities were available, the absence of structured programming limited opportunities for engagement, skill development, and behavioral stabilization. This lack of structure was especially concerning during periods of heightened tension, when consistent programming could have supported de-escalation and improved overall facility climate.

Staffing and Professional Culture

Staffing shortages were observed throughout the quarter and had a direct impact on operations. On multiple occasions, call-outs resulted in reduced staffing contributing to delays in school start times and challenges with supervision.

Concerns regarding staff conduct were also noted. During one interaction with OCO a supervisor abruptly left the unit in frustration saying, “I don’t care who they are, I run this unit and they got to leave soon”. This occurred while OCO was explaining to youth their rights. Youth expressed concerns about the supervisor’s behavior while he was on the unit and after he abruptly left the

unit. Youth also reported instances of inappropriate language used by staff, as well as concerns regarding a lack of access to case management services.

Religious Accommodations and Youth Support

During Ramadan, the facility made efforts to accommodate fasting youth, including providing adjusted meal schedules. These efforts were recognized as positive and demonstrated responsiveness to youth needs.

However, there were inconsistencies observed in the understanding and implementation of religious practices. For example, youth were not provided with alternative medication dispensing schedules in accordance with Islamic practices. This highlights the need for more structured support and education related to religious accommodations.

Youth also did not consistently receive religious items such as kufis and prayer rugs when requested.

Overall Assessment

The third quarter at BCJJC reflects a facility experiencing increasing operational strain, particularly following a series of serious incidents that disrupted safety, education, and daily routines. While there are clear examples of strong practice within the facility, including kitchen operations and periods of unit stability, these strengths were overshadowed at times by escalating violence, environmental concerns, and inconsistencies in service delivery.

Violent youth-on-youth assaults, as reflected in multiple incident reports, demonstrate a pattern that requires targeted intervention. Combined with physical plant issues, staffing challenges, and educational disruption, these factors contributed to a facility environment that fluctuated between stability and significant disruption.

Recommendations

1. Expand restorative justice interventions and structured mediation between units
2. Improve classroom transition protocols and supervision during movement
3. Enhance communication systems and ensure reliable access to radios to include earpieces
4. Address physical plant deficiencies, including plumbing, showers, and pest control
5. Ensure consistent access to basic needs, including clothing and hygiene items
6. Strengthen educational continuity during disruptions
7. Expand structured programming, particularly during weekends and post-incident periods
8. Standardize religious accommodations and provide qualified faith-based support
9. Clarify policies related to room restriction and behavioral interventions

10. Improve consistency in water access across all units
11. Reinforce and strictly enforce policies prohibiting the use of personal electronic devices in secure areas, including routine compliance checks, staff reminders, and appropriate accountability measures to prevent unauthorized photography and protect youth privacy

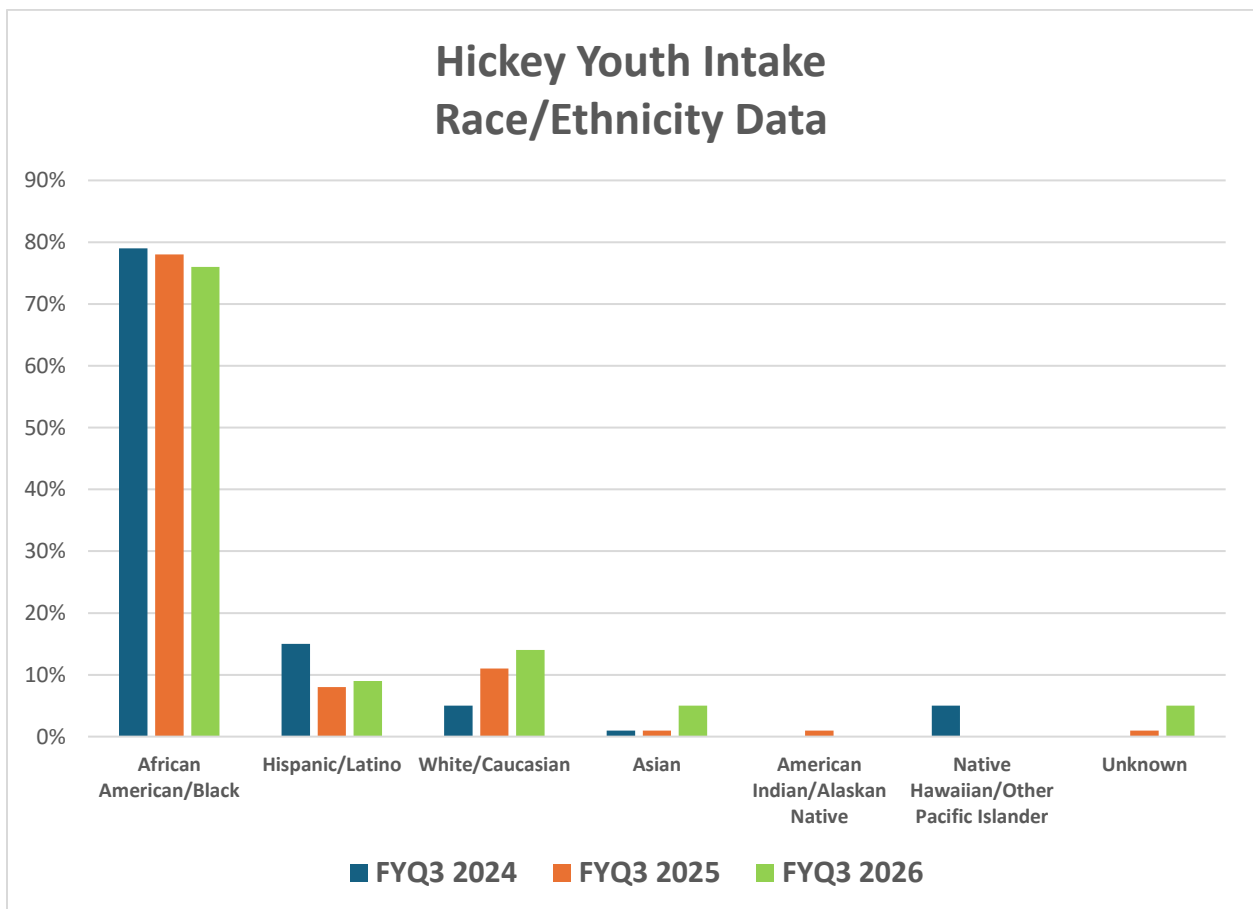
Charles H. Hickey, Jr. School

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-Jr-School.aspx>

Hickey – Selected Incident Categories	FYQ3 2024	FYQ3 2025	FYQ3 2026
Average Daily Population (ADP)	68	67	62
1. Youth on Youth Assault/Fight	38	47	43
2. Alleged Youth on Staff Assault	1	0	1
3. Physical Restraint	81	60	67
4. Use of Handcuffs and/or Shackles	18	2	2
5. Seclusion	20	10	2
6. Contraband	5	5	4
7. Suicide Ideation	6	4	3
8. Suicide Attempt	0	0	1
9. Self-Injurious Behavior	1	3	0

Data Highlights from DJS database

- Youth-on-youth incidents remain elevated but show a slight decrease from FY2025.
- Incidents involving physical restraint usage increased compared to the previous year, indicating continued reliance on physical interventions.
- Reported seclusion significantly decreased, reflecting a reduction in isolation practices.
- Contraband incidents remained relatively consistent, indicating ongoing supervision and search challenges.
- Behavioral health indicators reflect mixed trends, including one reported suicide attempt during the quarter.



Facility Overview and General Conditions

During the third quarter, the Charles H. Hickey, Jr. School (CHHJS) continued to serve youth with a range of behavioral, educational, and mental health needs.

Overall, the facility demonstrated mixed operational conditions. While certain areas, most notably food service operations, showed measurable improvement, concerns remain related to youth behavior, safety, and basic living requests.

Mental Health and Behavioral Health

Behavioral health concerns remained significant throughout the quarter. OCO identified multiple indicators of emotional distress, dysregulation, and crisis-level behavior, including suicide ideation and at least one reported suicide attempt.

The suicide attempt incident documented in IR #187714 underscores the need for continued focus on crisis response protocols and behavioral health supports. Youth were observed to experience difficulty maintaining emotional regulation, particularly during periods of stress or disruption.

These findings indicate a continued need for enhanced behavioral health services, consistent therapeutic engagement, and proactive intervention strategies.

Contraband and Facility Security

Contraband continues to present a persistent risk to facility safety and youth well-being. During the reporting period, multiple incidents involved the recovery of vape devices, suspected substances, and unauthorized materials.

- IR #187159 (February 3, 2026): Multiple vape devices were recovered from a youth's belongings.
- IR #187428 (February 18, 2026): A youth appeared to be under the influence; a sock with a vape pen and a liquid that appeared to be eyedrops were recovered from a sock in a shared area.
- IR #187438 (February 13, 2026): Youth tested positive for THC. A shakedown was ordered due to this positive test, during which a piece of paper with a Cash App account name was found in the involved youth's cell. The account name belonged to a Direct Care Staffer.

Contraband was often concealed in shared areas or personal belongings, raising concerns regarding search practices, supervision, and prevention strategies.

Youth Living Conditions and Basic Needs

Youth reported concerns related to basic living conditions and access to essential items. During site visits, OCO observed and documented issues including:

- Lack of properly fitting clothing and footwear
- Youth wearing worn or inadequate shoes
- Requests for coats, thermals, and other basic items

Physical Plant and Maintenance

Facility infrastructure issues impacted daily operations during the quarter. OCO identified concerns related to:

- Non-functioning showers, which disrupted hygiene routines
- Environmental conditions, including visible trash and debris around the campus, particularly near Clinton Hall and surrounding areas
- Kitchen equipment in need of repair

Trash Near Kitchen



Broken Kitchen Equipment



Broken Kitchen Equipment



While some issues were addressed in a timely manner, other findings highlight the need for proactive maintenance and environmental oversight.

Programming, Education, and Youth Engagement

During this reporting period Hickey has provided ongoing programs and events including youth - vs- staff basketball tournaments and a game night. The school and the facility held Black History month events to include guests from the community and family members. However, one housing unit reported a lack of activities. It is recommended that the facility ensures that all units have access to programming and recreation.

In addition, youth expressed interest in expanded access to religious services and faith-based programming, including both Christian and Islamic services, as well as access to religious items.

Communication Access and Family Engagement

During site visits this quarter, youth reported concerns regarding phone usage, including perceived GTL telephone deductions of minutes and not receiving the number of calls they are allotted each week.

In response to these concerns, case management staff reviewed phone records and shared documentation reflecting communication with GTL indicating that youth phone usage was aligning with the allotted minutes within the system. OCO commends Charles Hickey for these efforts. Additionally, youth expressed interest in receiving increased phone minutes beyond the current allotment.

The continued perception among youth that telephone minutes are being deducted indicates a need for improved case management to youth communication; this will ensure youth understand how the GTL system operates and how their calls are being tracked.

Multiple youth placed at CHHJS from outside jurisdictions expressed a desire to be relocated closer to their family members, emphasizing the importance of family connection and accessibility in supporting youth well-being.

Staff Misconduct

During the reporting period, OCO observed what appeared to be staff fatigue and dereliction of duty. During OCO observation a staff member assigned to a one-on-one appeared to be dozing while he was supposed to be supervising a youth.

OCO was made aware of an allegation involving inappropriate staff conduct with a Resident Advisor entering a youth room. This information was reported to the Office of Inspector General and shared with OCO as part of ongoing monitoring and oversight.

According to the reported allegation, on March 27, 2026, between approximately 7:30 PM and 9:00 PM, a Resident Advisor entered a youth's room while the youth was unclothed and engaged in a private act. The youth reported that he asked staff to wait prior to entry; however, staff proceeded into the room. The youth stated that no physical contact occurred during this interaction after the staffer entered his room.

Due to the nature of the allegation, including reference to potential PREA-related concerns, the matter was referred to the appropriate investigative authorities, including Child Protective Services (CPS) and the Maryland State Police (MSP), for review.

While the allegation was under investigation, the reported conduct raises concerns regarding staff adherence to appropriate room entry protocols, and communication with youth. Allegations of this nature can impact youth perception of safety and privacy.

Food Service Operations

Food service operations represented progress during the reporting period. OCO conducted multiple observations of kitchen conditions:

- February 6, 2026: Initial concerns were identified related to sanitation, labeling, and equipment
- February 26, 2026: Improvements were observed, including deep cleaning, proper food labeling, improved organization, and better equipment maintenance
- March 25, 2026: Compliance was observed, with clean and orderly operations, consistent labeling practices, and improved staffing structure

While dietary staffing concerns related to attendance were noted and referred to DJS leadership, overall food service operation adhered to standards.

Youth reported concerns regarding food quality, including instances of meals being undercooked.

Summary of Key Themes

Across the reporting period, several consistent themes emerged at CHHJS. These included concerns regarding contraband and basic needs. At the same time, the facility demonstrated the ability to implement improvements, particularly in food service operations and sustained positive youth engagement through programming and indicates that progress is achievable with focused attention and OCO oversight.

Recommendations

OCO recommends the following actions:

1. Ensure timely provision of essential items, including properly fitting clothing and footwear.
2. Strengthen contraband detection and prevention strategies through consistent searches and monitoring.
3. Address maintenance issues impacting daily living conditions.
- 4.. Ensure consistent GTL access and youth access to virtual calls as approved.
- 5.. Maintain improvements in food service operations to ensure continued compliance.

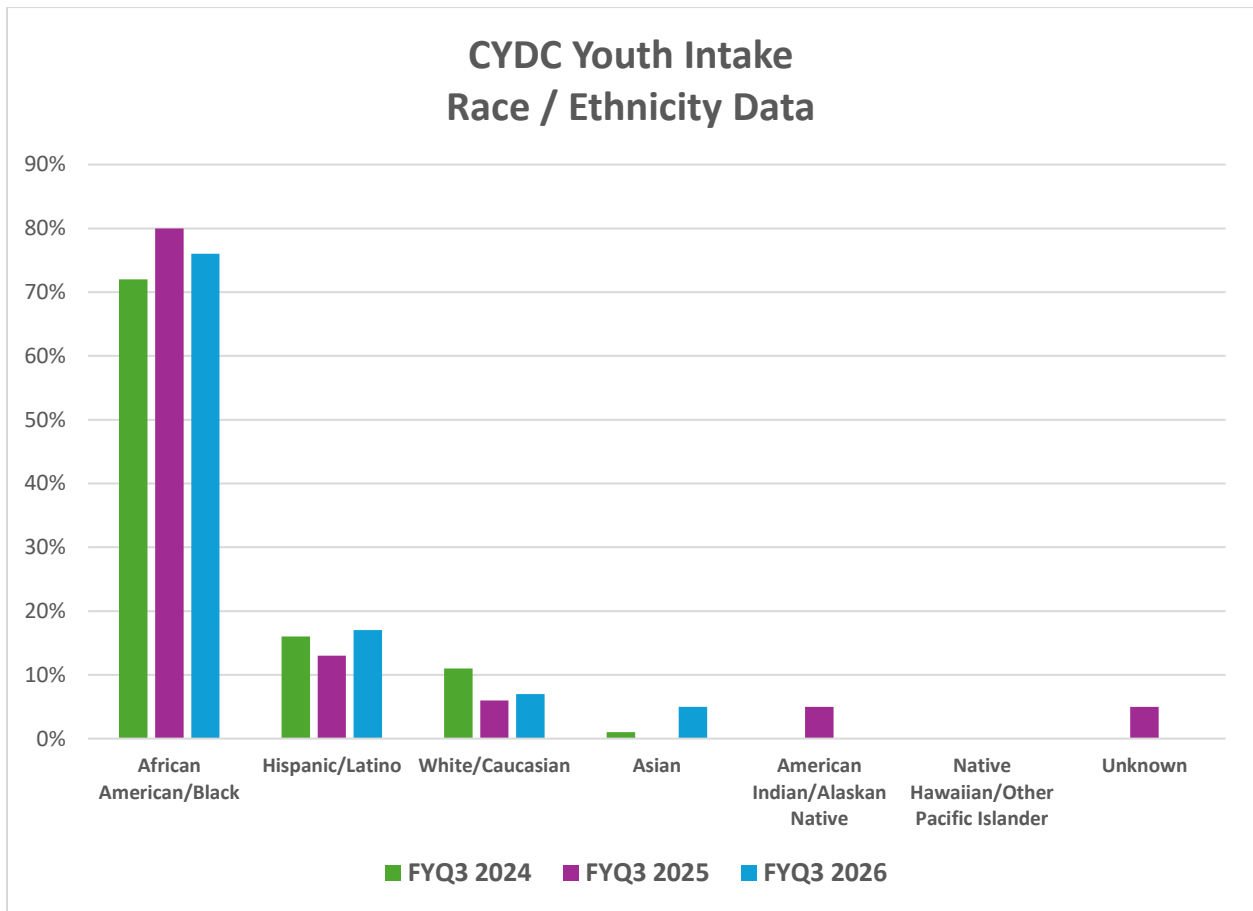
Cheltenham Youth Detention Center

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-youth-detention-center.aspx>

CYDC– Selected Incident Categories	FYQ3 2024	FYQ3 2025	FYQ3 2026
Average Daily Population (ADP)	69	65	60
1. Youth on Youth Assault/Fight	66	60	43
2. Alleged Youth on Staff Assault	4	3	2
3. Physical Restraint	76	59	57
4. Use of Handcuffs and/or Shackles	5	12	7
5. Seclusion	32	32	26
6. Contraband	5	4	5
7. Suicide Ideation	1	1	2
8. Suicide Attempt	0	0	0
9. Self-Injurious Behavior	2	3	0

Data Highlights from DJS database

- Youth-on-youth assaults decreased compared to prior years, indicating a reduction in reported youth aggression.
- Alleged youth-on-staff assaults declined, reflecting fewer direct staff safety incidents.
- Incidents involving physical restraints remained relatively consistent, with only a slight decrease from FY2025.
- Use of mechanical restraints (handcuffs/shackles) decreased compared to FY2025.
- Reported seclusion remains at a consistently elevated level despite a decrease, indicating continued reliance on restrictive interventions.
- Contraband incidents remained stable, suggesting ongoing prevention challenges.
- Behavioral health indicators show a slight increase in suicide ideation, with no suicide attempts or self-injurious behavior reported during the quarter.



Population and Demographic Trends

During FYQ3 2026, the average daily population at Cheltenham Youth Detention Center (CYDC) was 60 youth, including 32 youth charged as adults and 28 juvenile-detainees.

Youth of color continue to be disproportionately represented in the deep end of Maryland’s juvenile justice system and accounted for the majority of entries at CYDC during the quarter. African American/Black youth comprised 76% of youth entries, reflecting a slight decrease of 4% compared to the same period last year. Hispanic/Latino youth entries increased from 13% to 17%, indicating an upward trend in representation.

CYDC continues to receive a sizable population of youth who require interpretation services due to limited English proficiency. However, inconsistent access to interpreters remains a concern. During the quarter, one youth reported frustration after his interpreter routinely arrived late, took extended breaks, and left early, leaving him without services for much of the day. Upon transfer to a placement facility, the youth did not have an interpreter available upon his arrival. These gaps significantly limit youth’s ability to meaningfully participate in programming, access services, and communicate effectively.

Incident Trends and Facility Safety

There were measurable declines in several key incident categories during the reporting period. The average daily population decreased by approximately 8% compared to the same period last year. Youth-on-youth assaults and fights decreased by 28%, and the use of mechanical restraints declined by 42%. There was also a slight reduction in the use of physical restraints.

These reductions reflect sustained efforts by facility administration to improve operational stability and safety.

Seclusion Trends

Seclusion is a practice that involves isolating a young person in a room or cell away from peers and programming. Isolation can increase anxiety, psychological distress, and emotional dysregulation in adolescents, particularly those who have experienced trauma. Department policy restricts use of seclusion as a temporary response of last resort during a crisis involving an imminent threat of harm to self or others or risk of escape (*DJS Seclusion Policy RF-720-18*). Per DJS policy, these incidents must be recorded in the Department's incident database and must be accompanied by required documentation and monitoring safeguards including regular visual check-ins by direct-care staff, timely medical assessments, and periodic behavioral health assessments.

In line with decreases in other incident categories, the use of reported seclusion decreased by 23% compared to the same quarter last year and represents a positive development. However, CYDC continues to report the highest number of seclusions of all DJS-operated detention and placement sites. Additional efforts are needed to reduce staff reliance on this practice.

Use of Seclusion and Monitoring Concerns

Youth in seclusion are in a vulnerable state and are at risk for psychological harm and self-injury. Department policy establishes specific monitoring and documentation requirements for this reason. The DJS audit team found significant noncompliance with these requirements.

Behavioral Health Assessments: Behavioral health staff are required to assess youth within 30 minutes of being notified the youth has been placed on seclusion. If the clinician is not on-site, the assessment must be conducted on the phone and documented. An internal audit found 0% compliance with this requirement among reviewed records.

Nursing assessments: Nursing staff are required to complete assessments of youth as soon as possible and no later than 15 minutes after being notified that a youth is placed in seclusion. DJS auditors found that nursing staff were noncompliant with this requirement 20% of the time. Required two-hour follow-up visits were missed 33% of the time.

Direct-care visual checks: Direct care staff must make visual contact with youth in seclusion every 10 minutes. The facility was noncompliant with this requirement 21% of the time. These failures resulted in youth being placed in seclusion without the safeguards required to ensure their safety and well-being.

Unreported Seclusion Practices

In addition to documented incidents, OCO identified the use of unreported seclusion practices where youth were placed in seclusion as a behavior and conflict management tool and in response to staffing shortages. This practice falls outside of DJS policy and is not subject to required monitoring or safeguards.

Seclusion as a Behavior Management and Conflict Management Substitution

During one site visit, a youth was observed locked alone in a side room of a dayroom during the day with access to DVDs and video games. The youth reported high levels of agitation and anxiety due to isolation. Staff acknowledged that the youth had been approved for one-on-one support, which could not be provided due to staffing limitations, and this arrangement was used as a substitute.

In another instance, a youth experienced conflict with unit peers and was afraid for his safety. During an OCO visit, he was observed inside his cell. He was calm and not agitated. He told OCO that he had been kept in his cell for the last two days and wanted to be let out. Like the first youth, he had been assigned one-on-one support that the facility could not provide. He was given a DVD player to watch movies inside his cell instead of receiving appropriate intervention or support.

OCO raised concerns about the impact of these practices and their inconsistency with Department policy. Administrators were receptive to this feedback and partnered with OCO and the facility's mental health administrator to develop a trauma-informed, evidence-based facility operating procedure for youth who require individualized support due to behavioral or mental health needs. Continued oversight will be necessary to ensure this procedure is consistently implemented.

Seclusion in Response to Staffing Shortages

Seclusion was also used in response to staff shortages, resulting in prolonged confinement and disruption of services.

OCO confirmed through video review that youth on one unit were locked in their cells for extended periods across four consecutive days:

- During the first three days youth were rotated out in groups when staff arrived for the day shift.
- On the last day, youth were locked in cells until late afternoon with no rotation.
- Youth missed school and programming during this entire period.

On the third day of these conditions, multiple youth refused to lock-in after their two-hour rotation ended. Staff responded with inappropriate and inhumane restraint techniques, including lifting youth off their feet and carrying them to their cells, and dragging youth across the floor by their feet into their cells. These actions were not reported by staff or supervisors and were only identified through OCO's independent video review.

Although used during staffing shortages and often framed as a safety measure, prolonged seclusion undermines facility stability, increases youth distress, and is inconsistent with trauma-informed care principles.

Medical Response to Use of Force

Incident #187254, an allegation of staff misconduct investigated by the Department's Office of the Inspector General, revealed serious concerns regarding the medical response following use of force incidents.

In Incident #187237, a youth was restrained and placed in his room without a medical assessment following the restraint. Video footage confirmed that the youth was not brought to medical for an assessment after the restraint, nor did nursing staff visit the youth on the unit to assess him after the restraint. Despite having no visual or verbal contact with the youth, nursing staff documented that he refused medical treatment.

Approximately 90 minutes later, the youth reported experiencing a seizure while in his cell and requested medical attention but was told that medical staff were not on site.

He was not medically evaluated until the following afternoon, when he reported to nursing staff that direct-care staff had choked him, that he hit his head on the bed during the restraint, and that he later had a seizure (Incident #187254).

Delays in medical response following use of force incidents are not an isolated issue. Department standards require nursing staff to assess any youth involved in physical restraint as soon as possible and no later than 15 minutes after notification (*DJS Restraints Policy RF-718-18*). An internal audit found a compliance rate of only 48% based on a random selection of records, indicating that in nearly half of the cases, youth who were physically restrained did not receive timely medical assessments.

Additionally, this incident raised concerns regarding mandated reporting obligations, as nursing staff initially resisted completing required CPS notification forms following the allegation of staff misconduct.

Inventory, Maintenance, and Basic Needs

CYDC continues to experience long-standing challenges related to inventory management, maintenance, and access to necessities.

Observed issues during the quarter included:

- Lack of cleaning supplies, with staff purchasing items out-of-pocket
- A broken washing machine delaying laundering of youth clothing
- Units without consistent access to drinking water

- Delays in restocking incentive store items used to reinforce positive behavior under the Department’s behavior management program
- Unit TVs left broken for several months and replacements left uninstalled for extended periods
- Poor quality and inadequate supply of hygiene supplies, including non-absorbent towels and washcloths; youth on one unit reported that a lack of washcloths resulted in the same washcloths being used to clean the unit being laundered and redistributed for youth personal hygiene use
- Youth wearing damaged or poor-quality shoes that lacked support and deteriorated quickly

Damaged Shoe



Damaged Shoes



- Lack of accountability for inventory tracking and management and disorganization of the facility supply room. OCO repeatedly requested and never received the inventory tracking system used by the facility. Inventory ordering and distribution has been managed by one individual in upper management, and administration did not hold the supervisor accountable or change the inventory management process despite ongoing documented deficiencies.
- Physical plant conditions were also concerning. Youth reported cells with foul odors, lack of hot water, clogged toilets, and unsanitary conditions. One youth reported to OCO that when he transferred to a new unit, he was assigned a cell that was left filthy and smelled of urine from a previous occupant. He had to clean it himself to make it habitable. In Incident #187628, a youth refused to enter a foul-smelling cell and was restrained and forced inside after declining to clean it himself. A third youth reported placing towels over his toilet to quell the smell of sewage coming from it (pictured below).

Clogged Toilet with Sewage Odor



Due to the persistence of these issues, OCO escalated concerns to the Deputy Ombudsman to provide additional support, feedback and oversight to facility and Department leadership so that these issues could be comprehensively addressed.

Targeted recommendations by OCO that were accepted and implemented by administrators included:

- Cross-training individuals with demonstrated administrative ability in inventory and management tasks;
- Providing on-site guidance for how items should be organized, labeled, and tracked, resulting in better organization of supplies (see result below)

Inventory



- Implementing accountability measures for unit managers and mid-level management to help ensure that the basic needs of youth were met and that the unit had sufficient supplies

DJS Deputy Secretaries of Residential and Support Services and Executive leadership further supported OCO's findings and recommendations by:

- Mandating system-wide training on supply inventory and distribution processes for all facility administrators;
- Comprehensively addressing the issue of poor shoe quality by replacing the shoe brand with one of higher quality; and
- Providing increased support to CYDC administrators

These corrective actions represent meaningful progress and should be sustained through continued partnership and oversight.

Education Services and Access

The Juvenile Services Education Program (JSEP) is an independent education program housed within DJS facilities, and through its independent Board, is responsible for providing educational services to all students in DJS-operated detention and placement centers. For many young people at CYDC, school is the most structured, productive part of their day and one of the few spaces that prepares them for successful re-entry.

Providing consistent academic instruction is challenging in detention environments where security concerns often override educational needs. During the majority of site visits this quarter, some students were held back from attending school for the full school day because of conflict between or within residential units or due to staffing shortages. Students remaining on the unit during school hours are expected to complete packet work to maintain academic progress, with

teachers stopping in to assist as available. This practice was sporadic at best, and most students were disengaged from schoolwork and observed socializing with peers, playing cards, or watching television.

When security concerns, staff shortages, and youth conflict routinely keep youth out of school, students fall further behind academically and lose access to the structure and engagement that school provides.

OCO partnered with JSEP and DJS during the quarter to begin addressing these disruptions. OCO recommended that CYDC track when individual students are held back from school for security reasons, including staffing shortages, and document the services provided during those absences. The school at CYDC has begun tracking this data, including documentation of special education services received. This is an important first step in understanding the scope of the issue and developing strategies to address it.

Both OCO and JSEP also acknowledged that proactive conflict intervention can help prevent the incidents that remove youth from the classroom in the first place. Expertise in restorative practices and de-escalation is especially important in detention school settings. CYDC benefits from having a school psychologist, as well as access to facility-wide mental health services provided by a contracted vendor. These resources can be better leveraged in coordination to improve school and facility climate and reduce disruption to in-person instruction. OCO will continue to monitor this issue and partner with JSEP to build on the progress made this quarter.

Despite these challenges, JSEP continued to provide robust educational services and organized multiple academic events at CYDC during the quarter. These events were attended by families, students, staff, and guest speakers and provided opportunities to celebrate youth achievements and engage students in project-based learning. In addition to a system-wide commencement ceremony for high school graduates, students participated in National History Day competitions. CYDC students also took part in an event examining the history of Cheltenham through multiple disciplines, including science, math, history, and English. Their work is represented below.

Student Projects



Student Projects



Overall Assessment

Cheltenham Youth Detention Center demonstrated measurable improvements in incident reduction and population stabilization during FYQ3 2026. These trends reflect ongoing efforts by administration to improve safety and operational consistency.

However, serious concerns remain. These include the misuse and underreporting of seclusion, significant compliance failures in required monitoring and medical response, ongoing inventory and maintenance deficiencies, and disruptions to educational access.

While recent interventions related to inventory management and facility conditions are encouraging, sustained oversight and accountability are necessary to ensure long-term improvement.

Recommendations

1. Ensure consistent and reliable access to qualified interpreters, including during transitions between facilities
2. Ensure full compliance with seclusion monitoring requirements, including behavioral health, nursing, and direct care checks
3. Prohibit the use of isolation as a substitute for behavioral management or staffing shortages
4. Implement real-time supervisory review of seclusion practices and documentation
5. Provide targeted retraining to staff on seclusion protocols, timelines, and documentation requirements, with clear accountability for non-compliance
6. Develop proactive staffing plans to reduce reliance on prolonged confinement when staffing levels are low.
7. Hold staff accountable for use of force violations and reporting failures and ensure all incidents are accurately reported, reviewed, and addressed in a timely manner.
8. Strengthen medical response protocols to ensure timely assessments following all use of force incidents
9. Reinforce mandated reporting requirements and documentation standards for medical staff
10. Maintain and monitor newly implemented inventory management systems to ensure consistent access to supplies across units
11. Address maintenance issues promptly, including plumbing, water access, and cell conditions

12. Ensure youth have access to adequate hygiene items, clothing, and properly fitting, durable footwear
13. Minimize educational disruptions and ensure consistent access to instruction and services.
14. Continue tracking and monitoring missed instructional time and services provided to impacted students, using that data to improve the delivery of education services.
15. Increase use of restorative practices and behavioral supports within the school environment to reduce disruptions.
16. Strengthen coordination between education and mental health staff to better support student engagement and address underlying needs.

Lower Eastern Shore Children’s Center (LESCC)

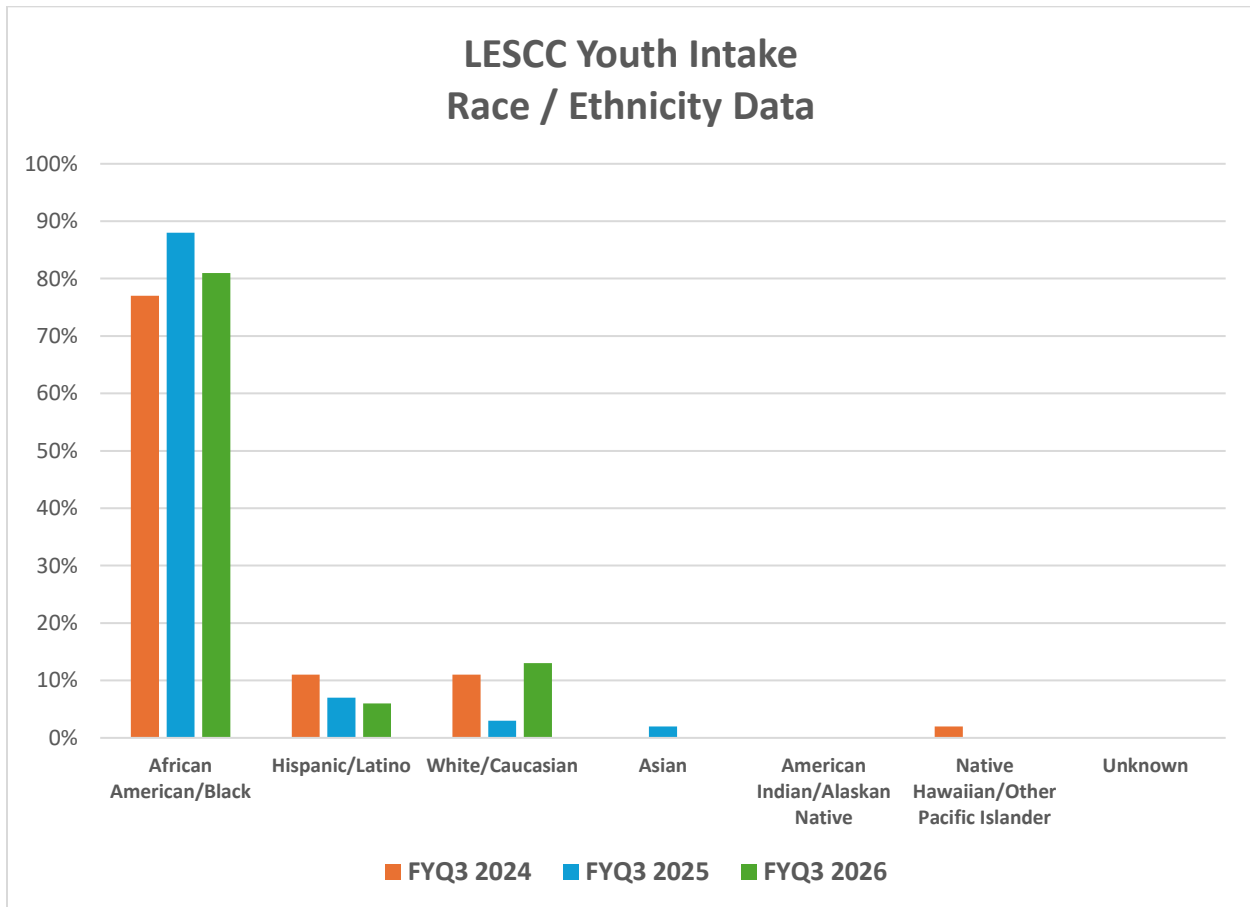
Facility Description: Hardware Secure (locked and fenced) Detention Center for Females and Males
 Population Served: Juvenile-Detained; Youth Charged as Adults; Pending Placement
 Location: Salisbury, MD (Eastern Shore)
 Rated Capacity: 24 Youth
 Operated By: Owned and Operated by the Maryland Department of Juvenile Services (The Department/DJS)
<https://djs.maryland.gov/Pages/facilities/Lower-Eastern-Shore-Children-Center.aspx>

LESCC – Selected Incident Categories	FYQ3 2024	FYQ3 2025	FYQ3 2026
Average Daily Population (ADP)	18	18	20
1. Youth on Youth Assault/Fight	10	17	23
2. Alleged Youth on Staff Assault	3	6	19
3. Physical Restraint	25	27	97
4. Use of Handcuffs and/or Shackles	0	1	1
5. Seclusion	0	1	3
6. Contraband	1	2	0
7. Suicide Ideation	1	5	3
8. Suicide Attempt	0	0	1
9. Self-Injurious Behavior	2	0	2

Data Highlights from DJS database

- The facility experienced an 11% increase in Average Daily Population (ADP).
- Youth-on-youth assaults increased significantly, indicating elevated levels of conflict.

- Alleged youth-on-staff assaults and physical restraints increased sharply and represent a significant outlier compared to prior years.
- Seclusion increased slightly but remains relatively limited overall.
- Behavioral health indicators include one reported suicide attempt.



Population and Incident Trends

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.

However, there were modest declines in entry rates for youth of color. African American/Black youth comprised 81% of youth entries during the quarter, an 8% decrease compared to the same period last year. Hispanic/Latino youth entries also declined slightly by 1% when comparing the current reporting period to the same period last year.

The average daily population increased by 11% compared to the same period last year. During the same timeframe, youth-on-youth fights and assaults increased by 35%, while youth-on-staff assaults and the use of physical restraints more than tripled. LESCC reported the highest number of youth-on-staff assaults and physical restraints among all DJS-operated detention and placement centers during the quarter.

Facility Overview

LESCC is a smaller detention facility, and vulnerable youth and those with complex behavioral or mental health needs are often transferred there from other detention centers. It is also the only detention center that houses both girls and boys. A small number of youth with severe behavioral and mental health challenges accounted for the majority of staff assaults and physical restraints during the quarter.

Maryland continues to face a shortage of residential treatment centers for high-acuity youth, particularly girls. As a result, youth with the highest needs often remain in detention for extended periods while awaiting appropriate placement. Two youth at LESCC with extensive trauma histories have been detained for close to a year. One youth was waiting for placement nearly half of a year before being sent to an out-of-state residential treatment center. Another has been denied acceptance into multiple out-of-state programs, and the Department continues to search for other options.

Detention is designed to be short-term and is not equipped to meet the needs of youth requiring intensive behavioral health treatment. Prolonged detention can worsen underlying mental health conditions and increase behavioral and emotional instability. Staff are often left managing complex needs without the appropriate tools, resources, and specialized training, which can lead to increased reliance on restraints and other physical interventions. These responses can further escalate situations, contribute to re-traumatization, and increase staff burnout.

In addition to challenges associated with high-needs youth, managing group dynamics and youth conflict was particularly difficult during the quarter. To address ongoing conflict, administrators separated youth into smaller groups despite limited space. While this strategy was undertaken to maintain safety, it strained staffing resources and disrupted access to education and programming.

Given the complexity of youth needs and the co-ed population, LESCC would benefit from expanded mental health resources and greater use of restorative approaches to constructively address youth behavior and conflict without relying on separation, which disrupts facility schedules and access to services.

Activities

Youth consistently reported that activities were limited and that planned programming did not occur as scheduled. In DJS Grievance 19896, multiple boys reported a lack of activities during January. Girls similarly reported limited structured activities during leisure time.

Youth expressed interest in additional recreational options, including new DVD movies to replace scratched disks, additional PS5 video games, and expanded book options such as comic books, graphic novels, and science fiction.

Facility leadership acknowledged that ongoing incidents interfered with the ability to implement activity schedules. However, operational challenges should not prevent programming. Consistent access to structured and engaging activities is an important tool for reducing stress and tension, improving behavior, and supporting a more positive facility environment.

Education

Educational space at LESCC is limited, creating challenges in accommodating students from three living units. The facility has two classrooms and relies on shared spaces such as the gym and visitation area for instruction. These spacing challenges are compounded when youth are separated into smaller groups to manage conflict.

As a result, not all youth consistently receive a full day of in-person instruction. During the quarter, two girls, on separate occasions, were separated from their peers and did not attend school in a classroom setting. Instead, they completed packet work on the unit with limited teacher support. One girl described this experience as “educational abandonment.”

Unlike larger detention centers, LESCC does not have a library or media center, which could enhance the learning environment.

Despite these constraints, students represented LESCC at system-wide academic events, placing first and third in Black History and National History Day competitions.

Safety and Security

Sallyport areas throughout the facility are not equipped with cameras, which limits the ability to review incidents that occur in these locations. Several incidents, including two restraints that led to staff misconduct allegations, occurred in sallyport areas during the quarter, including Incidents #187660, #18766, and #187948. Cameras should be installed in these areas to strengthen oversight and accountability.

Physical Plant Issues

Multiple physical plant concerns were observed throughout the quarter. Youth and staff reported multiple rodent sightings over several weeks at the beginning of the quarter. One youth reported killing a mouse in the gym area during recreation. Mouse traps were visible and accessible to youth during an OCO facility walkthrough, in violation of Integrated Pest Management protocols.

Visible Mouse Trap



Girls also reported concerns about unit cleanliness, including flying bugs on the units and dirty walls and floors.

Laundry and shower areas were reportedly unclean, and showers smelled musty. OCO also

Uncleaned Floor



Uncleaned Floor



Uncleaned Floor and Wall



Uncleaned Floor



Uncleaned Laundry Area



Uncleaned Shower



Water Damage on Ceiling



Damaged Cabinets



observed missing borders on cabinets, which created a potential injury risk, as well as water damage on the ceiling.

After consistent findings of physical plant issues by OCO, the facility took steps to address these concerns, including increasing the frequency of pest control services, initiating a deep cleaning plan, and repainting units. These efforts are a positive step, and continued attention to maintenance and cleanliness will be important moving forward.

Recommendations

1. Expand access to mental health services to better support the needs of high-acuity youth.
2. Increase the use of restorative practices to address youth conflict and use de-escalation strategies to reduce reliance on physical restraints.
3. Expand treatment services, including placement options, for high-needs youth to avoid prolonged detention.
4. Ensure consistent implementation of structured recreational and leisure activities, even during periods of operational challenges.
5. Provide youth with additional leisure items, including updated movies, games, and reading material aligned with their interests.
6. Improve access to educational services by minimizing disruptions caused by group separation and exploring alternative educational supports.
7. Install cameras in sallyport areas to improve incident review, transparency, and accountability.
8. Continue physical plant improvements, including pest control, deep cleaning, and routine maintenance, and ensure cleaning vendors meet established standards.
9. Conduct regular leadership walkthroughs to proactively identify and address maintenance and cleanliness concerns.

Western Maryland Children’s Center (WMCC)

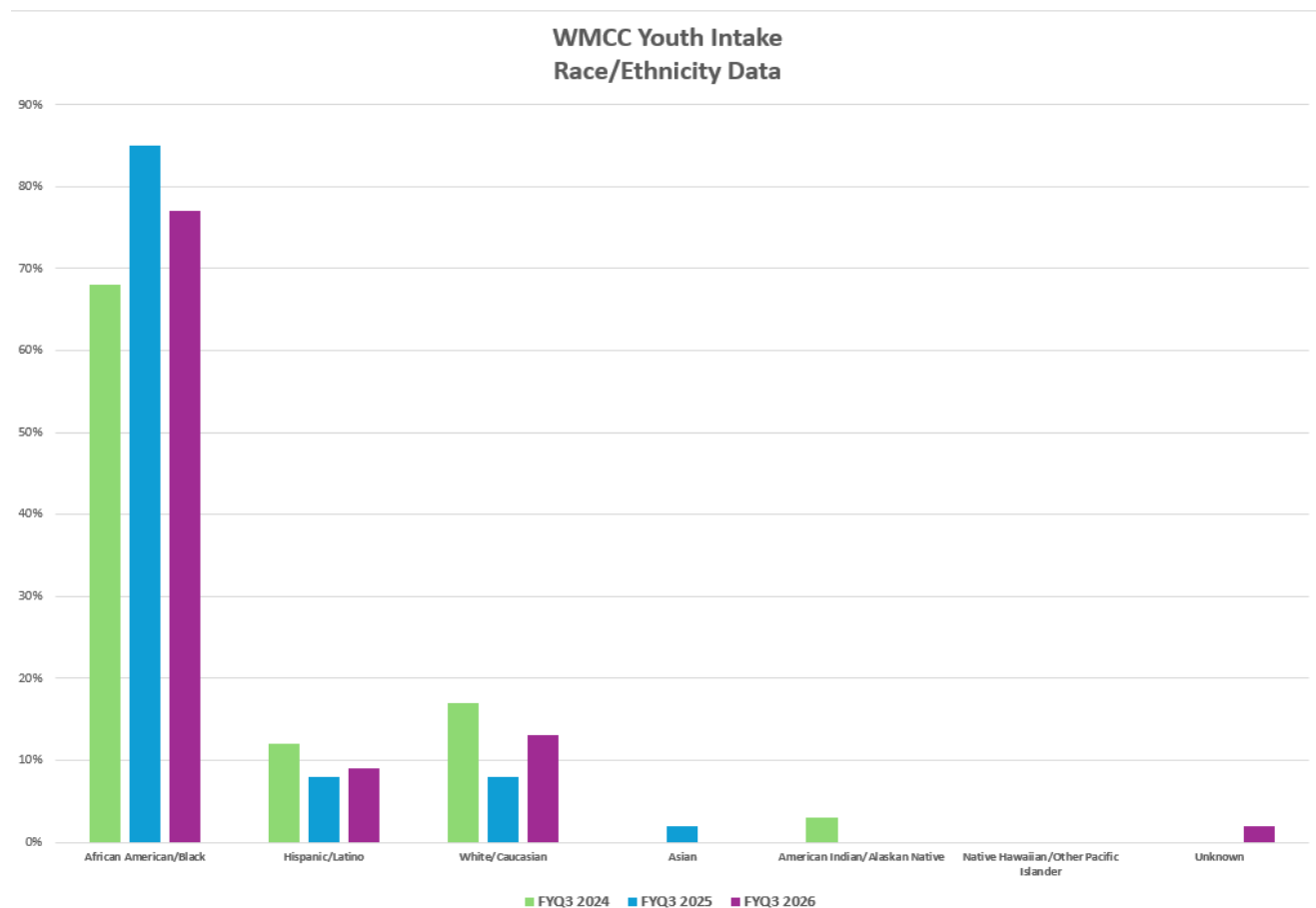
Facility Description: Hardware Secure (locked and fenced) Detention and Placement Center for Females
 Population Served: Juvenile-Detained; Youth Charged as Adults; Pending Placement; Placement
 Location: Hagerstown, MD (Western Maryland)
 Rated Capacity: 18 Detention Beds
 6 Placement Beds
 24 Youth Total
 Operated By: Owned and Operated by the Maryland Department of Juvenile Services (The Department/DJS)
<https://djs.maryland.gov/pages/facilities/western-maryland-children-center.aspx>

WMCC – Selected Incident Categories	FYQ3 2024	FYQ3 2025	FYQ3 2026
Average Daily Population (ADP)	19	16	18
1. Youth on Youth Assault/Fight	12	29	14
2. Alleged Youth on Staff Assault	1	10	4
3. Physical Restraint	49	78	42
4. Use of Handcuffs and/or Shackles	10	21	8*
5. Seclusion	3	24	12*
6. Contraband	2	0	2
7. Suicide Ideation	0	8	6*
8. Suicide Attempt	0	4	1
9. Self-Injurious Behavior	0	2	6
*Highest rates of seclusion per capita based upon ADP and highest number of suicide ideation, and mechanical restraint usage compared to all other facilities			

Data Highlights from DJS database

- Youth-on-youth assaults decreased significantly from FY2025 levels.
- Alleged youth-on-staff assaults, incidents involving physical restraints, reported seclusion, and mechanical restraint usage all declined.
- Despite these reductions, seclusion and mechanical restraint usage remained elevated.
- Behavioral health indicators remain a major concern:
 - High suicide ideation
 - One suicide attempt
 - Increased self-injurious behavior
- Contraband incidents remained low but present.

Overall, while violence-related indicators declined, behavioral health acuity and reliance on restrictive interventions remain significant concerns.



Population and Incident Trends

During FY26 Q3, WMCC maintained an average daily population of 18 youth, reflecting a slight increase from the previous year. Data trends indicate that youth-on-youth assaults decreased significantly compared to FY25 levels, and both alleged youth-on-staff assaults and physical restraints also declined.

Despite these reductions, the facility continued to report elevated use of restrictive interventions. WMCC recorded the highest rates of seclusion per capita based upon ADP, as well as the highest levels of suicide ideation and mechanical restraint usage, when compared to other DJS-operated facilities during the reporting period.

Behavioral health indicators remained a primary concern. The facility reported multiple instances of suicide ideation, one suicide attempt, and an increase in self-injurious behavior. While contraband incidents remained relatively low, they continued to occur and contribute to overall safety concerns.

These trends suggest that while overt violence has decreased, underlying behavioral health acuity and reliance on restrictive practices remain significant challenges impacting overall facility stability.

Key Observations

WMCC demonstrated improvement in several incident categories during the reporting period, particularly in youth-on-youth assaults and physical restraints. However, ongoing concerns persist related to behavioral health acuity, staffing limitations, environmental conditions, and the overall quality of life for youth.

Early in the quarter, facility leadership identified increasing interpersonal conflict among youth. This concern remained consistent with OCO observations during site visits conducted throughout February and March 2026. Across visits, the facility appeared to be operating under sustained strain due to staffing shortages, hospital supervision demands, and the complexity of managing youth with significant behavioral health needs within a detention and placement setting.

Behavioral Health and Youth Acuity

WMCC continues to serve girls with significant trauma histories and complex behavioral health needs. OCO observed ongoing emotional dysregulation, peer conflict, and elevated self-harm risk among youth. Access to consistent calming supports appeared limited, and environmental stressors including graffiti, cold room temperatures, and overall unit conditions likely contributed to increased distress.

These observations are consistent with the elevated behavioral health indicators reflected in incident data and reinforce concerns about whether the current environment is adequately equipped to support high-acuity youth.

Room Graffiti



Room Graffiti



Room Graffiti



Room Graffiti



Room Graffiti



Use of Restrictive Interventions

Although reductions were observed in some incident categories, reliance on restrictive interventions remains a concern. OCO identified instances where seclusion was used in response to operational limitations rather than immediate safety threats. For example, IR #187485 reflected a unit being placed on seclusion due to insufficient staffing.

The use of restrictive practices to manage staffing shortages or operational constraints raises significant concerns regarding policy compliance, youth well-being, and long-term facility stability.

Staffing, Intake, and Operations

Staffing shortages continued to impact daily operations, including movement, supervision, and access to services. Youth reported remaining in their rooms until approximately 8:00 AM, as well as delays in case management contact and commissary access.

OCO requested clarification regarding reported deficiencies in the behavioral health intake process and recommended consideration of dedicated intake coverage to ensure consistency and timely assessment.

Medical staff expressed concerns regarding the current unit-based medication pass model, noting that it may be disruptive to operations and presents potential safety risks. They highlighted that other smaller facilities escort youth to medical for their medication.

Hospitalization and Placement Suitability

The presence of high-acuity youth requiring hospitalization continued to place additional strain on staffing and operations. OCO remains concerned that some youth at WMCC have needs that exceed the facility's intended design, contributing to instability and increased reliance on restrictive interventions.

These concerns highlight broader system challenges related to placement availability and the need for appropriate treatment environments for youth with complex needs.

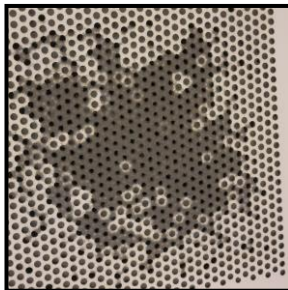
Physical Plant and Environmental Conditions

OCO observed persistent concerns related to the physical plant and overall environment. These included graffiti throughout units, unclean showers and vents, cold room temperatures, inconsistent access to hot water, unsecured doors and storage areas, and unsafe fixtures such as exposed cords.

Concerns were also noted in shared spaces, including the dining area, where cleanliness issues were observed. Classroom 2 was identified as not locking properly, presenting an additional safety concern.

While camera and door system upgrades were noted as a positive development, environmental conditions continue to negatively impact both youth well-being and overall facility climate.

Dining Hall Vent



Dining Hall Wall



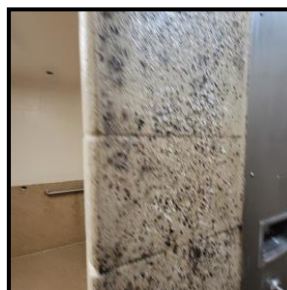
Unit Graffiti



Hanging Phone Cord



Shower Wall



Kitchen Operations and Food Safety

OCO observed both positive practices and ongoing concerns related to kitchen operations. Youth engagement in food taste-testing was a notable strength, reflecting efforts to incorporate youth voice.

However, concerns were identified regarding food safety, including the presence of moldy food and unlabeled items. These observations raise concerns about storage practices, inventory management, and adherence to food safety protocols. OCO also addressed unauthorized distribution of peanut products, which facility leadership confirmed has been corrected.

Unlabeled Food



Moldy Cheese



Youth Basic Needs and Gender-Responsive Care

Youth consistently reported challenges related to basic needs, including limited shower access, inadequate bedding, insufficient hygiene products, improperly fitting clothing, and lack of culturally appropriate hair care items.

OCO also received concerning reports that access to hygiene products and showers may have been impacted by group accountability practices rather than individualized behavior management. These practices raise concerns regarding equitable access to basic necessities and alignment with trauma-informed care principles.

Placement Conditions and Gender Equity

Youth reported that their conditions were largely indistinguishable from detention. Concerns included delays in access to MP3 players, lack of clarity regarding tablet rollout, and limited recreation, programming, incentive opportunities compared to male facilities.

OCO continues to have concerns regarding equity in placement conditions and the need to ensure that placement environments meaningfully differ from detention in both structure and opportunity.

Programming and Recreation

Youth consistently reported limited programming, particularly on weekends, and indicated that posted activity schedules did not reflect actual programming. Youth expressed interest in more meaningful engagement opportunities, including job readiness programming, certification opportunities, and self-care and wellness programming.

Limited access to structured programming reduces opportunities for positive engagement and may contribute to increased behavioral challenges.

Education and School Climate

OCO observed that staffing shortages impacted classroom instruction and coverage. Youth raised concerns regarding fairness, support, and consistency within the educational environment.

Given these observations, OCO recommended further review of educational practices through an equity lens to ensure all youth receive consistent and meaningful instruction.

Safety and Security

Ongoing safety concerns included camera functionality issues, door control errors, obstructed visibility in certain areas, and potential risks related to unsecured items that could be weaponized.

These concerns highlight the need for continued attention to infrastructure, supervision, and control room operations.

Grievance Access

Youth reported difficulty accessing grievance forms, raising concerns regarding transparency, accountability, and the ability of youth to effectively voice concerns.

Religious and Spiritual Supports

Youth expressed interest in increased access to religious materials and programming, including Islamic books and faith-based instruction. OCO reiterates the importance of ensuring access to spiritual support as part of holistic youth development.

Leadership Presence

Youth emphasized the importance of visible leadership engagement on the units. Positive feedback was noted regarding assistant superintendent engagement, reinforcing the value of consistent leadership presence in supporting facility climate.

Youth Feedback

Across site visits and engagement, youth consistently raised concerns related to living conditions, hygiene access, placement equity, limited programming, grievance access, recreation,

and the need for increased therapeutic and spiritual supports. Youth also expressed concerns regarding fairness in incentives and commissary practices.

Notable Incidents and Oversight Activity

OCO monitored conditions at WMCC through ongoing site visits, incident report reviews, and engagement with facility leadership. As part of this oversight, OCO reviewed multiple incidents during the reporting period, including IR #187498, IR #187495, IR #187478, and IR #187461, which collectively highlight challenges related to supervision, environmental controls, and response coordination.

For example, IR #187495 (March 2, 2026) involved a verbal altercation between youth that escalated into a physical confrontation during dinner. The situation intensified when additional youth entered the area through an unsecured door and joined the incident. While staff ultimately intervened and utilized physical restraints to regain control, administrative review noted concerns regarding security (unsecured doors), delayed removal of involved youth, and opportunities for more coordinated staff response and de-escalation.

Similarly, IR #187461 (February 26, 2026) involved a youth escalating behavior in a classroom setting, requiring both verbal redirection and physical intervention by staff. This incident reflects ongoing challenges in managing youth behavior in structured settings and the need for consistent de-escalation strategies.

In a separate incident occurring on March 1, 2026, a youth was observed engaging in unsafe behavior on the unit, including climbing on chairs and facility fixtures, which escalated into a physical altercation with staff. This incident further underscores the importance of early intervention and consistent supervision to prevent escalation.

IR #187485 was reviewed due to concerns regarding the use of seclusion during a period when staffing levels were limited. Based on the information available, seclusion was utilized in a context that raised questions about whether it was being used solely in response to an immediate safety risk, as required by Department policy, or as part of broader unit management during staffing constraints. While maintaining safety during staffing shortages is critical, the use of seclusion under these conditions underscores the importance of ensuring that such interventions remain consistent with policy requirements and are not used as a substitute for appropriate supervision, de-escalation, or staffing support.

Additional concerns raised during the reporting period included reports of limited dedicated intake staffing with specialized expertise in the youth intake process, as well as broader questions regarding the appropriateness of a detention setting for youth with higher acuity needs.

Positive Practices

Despite the challenges identified, several positive practices were observed. These included upgrades to camera and door systems, youth engagement in food taste testing, and opportunities for off-campus programming.

OCO also observed prompt maintenance responses to certain facility issues and responsiveness from staff regarding food safety concerns. Partnerships, including collaboration with the Hope Center of Hagerstown, were also noted as strengths. Additionally, the provision of sweatpants to

girls in placement and positive staff engagement contributed to improved interactions with youth.

Food Taste Testing Items



Recommendations

1. Expand behavioral health services and trauma-informed interventions to better support high-acuity youth.
2. Reduce reliance on seclusion and mechanical restraints and ensure use aligns with policy.
3. Prohibit the use of seclusion as a response to staffing shortages.
4. Address staffing shortages impacting supervision and daily operations.
5. Assign dedicated intake staff and strengthen intake processes.
6. Review behavioral health audit findings and address identified deficiencies.
7. Evaluate medication pass procedures to improve safety and efficiency.
8. Ensure full functionality and maintenance of camera and door systems.
9. Address environmental and sanitation concerns across all units.
10. Ensure consistent access to basic necessities, including hygiene and clothing.
11. Provide culturally appropriate hygiene and hair care products.
12. Eliminate group accountability practices that restrict access to basic needs.
13. Ensure placement conditions are meaningfully distinct from detention.
14. Standardize access to incentive-based supports such as MP3 players.

15. Ensure consistent access to grievance forms and processes.
16. Expand structured programming, particularly during weekends.
17. Ensure recreation schedules accurately reflect actual programming.
18. Expand faith-based and spiritual programming opportunities.
19. Strengthen control room procedures and overall safety protocols.
20. Advocate for appropriate placement options for high-acuity youth.
21. Ensure fairness and consistency in commissary and incentive systems.
22. Increase visible leadership presence on units.
23. Maintain strict adherence to food safety and allergen control protocols

Individual Facility Reports: Placement Centers

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>

Victor Cullen – Selected Incident Categories	FYQ3 2024	FYQ3 2025	FYQ3 2026
Average Daily Population (ADP)	26	25	24
1. Youth on Youth Assault/Fight	11	10	4
2. Alleged Youth on Staff Assault	1	6	2
3. Physical Restraint	13	25	15
4. Use of Handcuffs and/or Shackles	4	18	5
5. Seclusion	2	2	0
6. Contraband	5	6	5
7. Suicide Ideation	1	1	1
8. Suicide Attempt	0	0	0
9. Self-Injurious Behavior	1	0	0

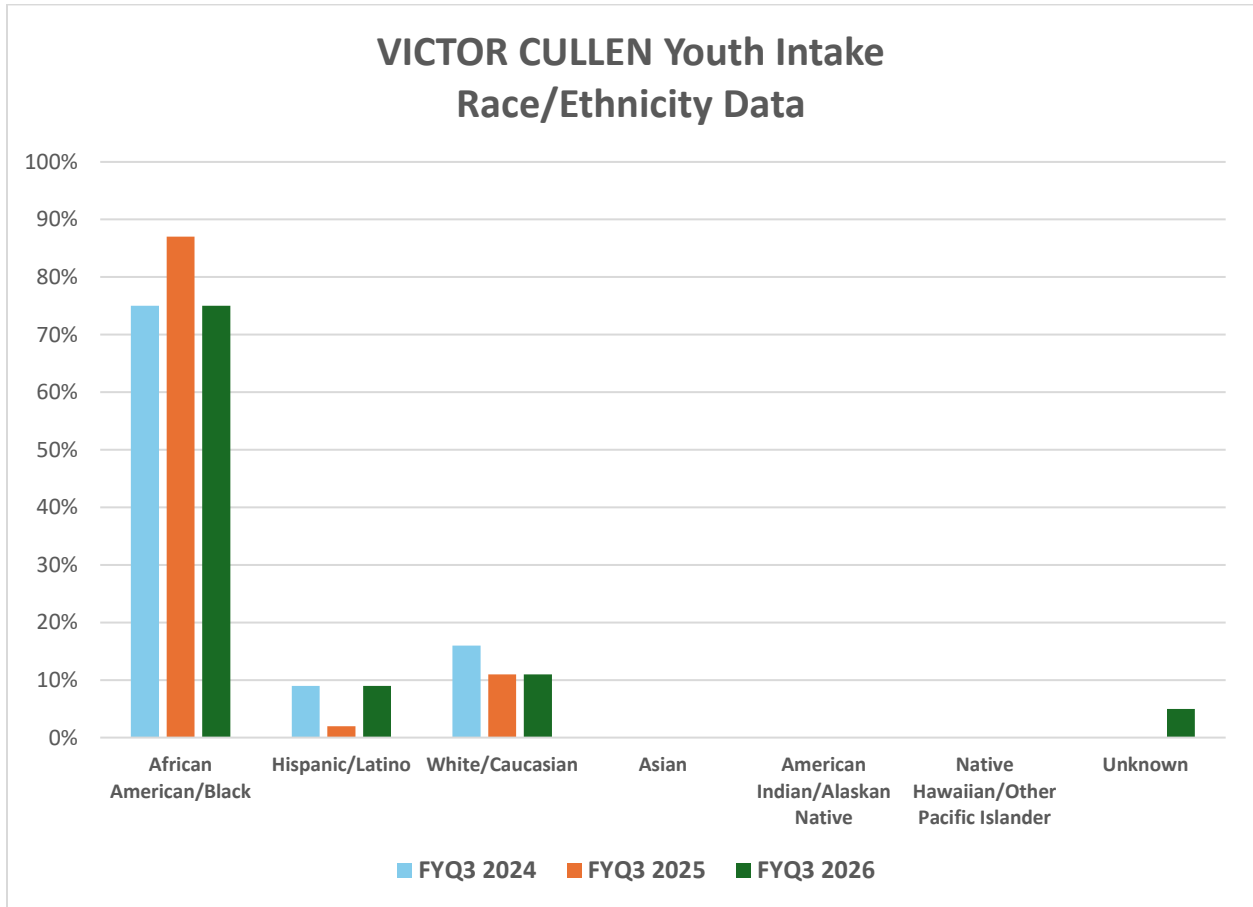
Data Highlights from DJS database

- Youth-on-youth assaults decreased significantly (10 → 4)
- Incidents involving physical and mechanical restraints declined
- Reported seclusion was eliminated entirely during the reporting period

- Alleged youth-on-staff assaults decreased
- Suicide-related indicators remained stable with no suicide attempts

Overall, the data reflects improved behavioral stability and reduced reliance on high-level interventions.

While these trends are encouraging, continued monitoring is necessary to ensure sustained progress, particularly regarding use-of-force practices and youth climate.



Facility Overview and Operations

Victor Cullen Center (VCC) is a hardware-secure placement facility serving committed male youth. During the third quarter of FY2026, the facility demonstrated measurable improvement across several key safety indicators while maintaining a relatively stable population.

Youth-on-youth assaults decreased compared to prior years, and both physical and mechanical restraints declined. Notably, the use of seclusion was eliminated during the reporting period. Alleged youth-on-staff assaults also decreased, and suicide-related indicators remained stable, with no suicide attempts reported.

These trends suggest improved behavioral stability and a reduced reliance on high-level interventions. Youth behavior during periods of disruption, including temporary changes to school operations, remained generally stable. Facility leadership reported consistent operations overall, and OCO observed staff engagement and responsiveness during site visits.

At the same time, while safety outcomes improved, OCO identified ongoing concerns related to environmental conditions, programming access, physical plant issues, and service delivery. These findings indicate that, although the facility is moving in a positive direction, additional work is needed to ensure consistency in youth experience and alignment with expected standards.

Environmental Health, Education, and Physical Plant

One of the most significant concerns identified during this reporting period was the condition and continued use of the school trailer for instructional purposes.

OCO conducted multiple site visits in January 2026 focused on the trailer following staff concerns related to air quality. Based on direct observation, the structure appears to have exceeded its intended lifespan and shows signs of ongoing deterioration. Evidence of water intrusion, structural wear, and repeated patchwork repairs was observed throughout the space. Doors were not consistently secure, and there were visible signs of settling and instability.

Air quality concerns were also noted. OCO observed residue on vents and interior surfaces consistent with possible mold or environmental contamination, along with dirty and clogged ventilation systems. Staff reported respiratory concerns, and rodent droppings were observed within classroom vents. Additional evidence of wildlife intrusion beneath the trailer further raised concerns about contamination and exposure risks.

HVAC systems appeared inconsistent and unreliable, and airflow and temperature regulation were not optimal. The crawl space beneath the structure showed signs of water erosion and environmental degradation.

While subsequent testing did not confirm the presence of black mold, findings included the presence of other mold spores and concerns related to humidity. OCO also noted that cleaning and re-occupancy timelines appeared inconsistent with environmental health guidance, particularly where ventilation and drying time are critical. Instructional spaces were reoccupied shortly after cleaning without clear evidence that full remediation standards were met.

During this period, school operations were also disrupted. There were multiple days when teachers were not present, and youth were temporarily out of formal classroom instruction. In response, staff implemented structured recreational activities to maintain engagement and supervision. Instruction was also temporarily relocated to housing units at times. While these adjustments were intended to be short-term, they highlight the need for a sustainable plan that ensures continuity of education in a safe and appropriate environment.

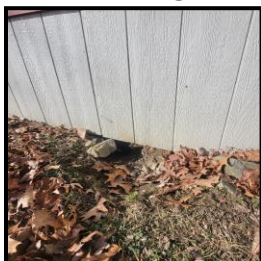
Beyond the school trailer, additional physical plant issues were observed across the facility. On Raine Cottage, youth reported that the shower light was not functioning, resulting in youth bathing without adequate lighting. On Prettyman Cottage, urinals were out of service and covered with trash bags due to ongoing plumbing and odor concerns. A water fountain on the

same unit was reported by staff to have filtration issues and an odor, though youth indicated they continued to use it due to limited alternatives.

Additional concerns included damaged clothing items, delays in clothing distribution, and inconsistent functionality of laundry equipment. While work orders were reportedly submitted in several instances, resolution timelines appeared delayed.

Collectively, these conditions reflect the need for more consistent maintenance practices, timely repairs, and clear communication to ensure that youth have access to safe and functional living and learning environments.

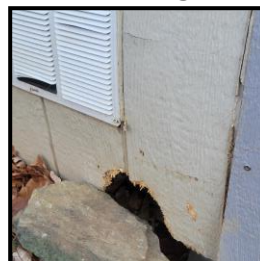
School Damage



School Damage



School Damage



School Damage



School Damage



Mouse Droppings



Unclean Vent



Water Damage



Youth Safety, Use of Force, and Reporting Practices

During the reporting period, OCO reviewed a use-of-force incident that raised concerns regarding staff conduct and reporting integrity. Video footage reviewed appeared to show physical contact initiated by staff that was inconsistent with expected standards. The incident also raised concerns regarding discrepancies between written reports and observed conduct, as well as the involvement of a non-involved youth assisting in a restraint.

While DJS reported that the matter was addressed through internal processes, the incident highlights the importance of strict adherence to Safe Crisis Management (SCM) protocols and the need for accurate and consistent documentation. Alignment between incident reports and

video evidence remains critical to ensuring accountability and maintaining confidence in facility practices.

Youth Engagement, Programming, and Daily Structure

Youth consistently reported limited access to structured programming and expressed concerns about periods of idleness. At the same time, youth demonstrated a strong interest in engagement and participation in constructive activities.

Multiple youth requested access to workforce development opportunities, including participation in the DJS-sponsored work program (referred to as YOLO) and vocational training such as Home Depot certification. One youth specifically requested the ability to track accumulated work hours in a structured format, reflecting a desire for accountability and motivation tied to progress.

Despite this interest, programming availability during the reporting period was limited. The YOLO program was suspended, and additional work opportunities were constrained by staffing and logistical challenges. While efforts were made to explore exceptions and provide alternatives, access to consistent programming remained restricted.

These findings indicate that youth at VCC are actively seeking opportunities for engagement and skill development. The primary barrier is not lack of interest, but limitations in program availability and infrastructure.

Youth Climate, Staff Interactions, and Case Management

Youth reported concerns related to staff interactions, including allegations of inappropriate comments in classroom settings. While not independently verified in all cases, these reports highlight the importance of maintaining professionalism and respect in staff-youth interactions.

Youth also expressed concerns about potential retaliation when raising issues or speaking with OCO. Although these concerns were not substantiated in all instances, the consistency of the reports is notable. OCO emphasized the importance of reinforcing SB 134 mandates and ensuring that youth are able to communicate concerns freely.

Concerns related to case management were also identified. Youth reported delays in meeting with assigned case managers, confusion regarding phase progression, and limited communication regarding their status. In some instances, youth reported not having met with their assigned case manager after arrival. Staffing limitations, including vacancies and temporary absences, were identified as contributing factors.

Behavioral health continuity was also raised, with at least one youth requesting continued connection to a prior provider. These concerns highlight the importance of consistent access to case management and behavioral health services.

Positive Practices and Outcomes

Despite the concerns identified, OCO observed several positive practices during the reporting period. The reduction in incidents and elimination of seclusion represent meaningful progress.

Youth behavior remained stable during operational disruptions, and staff demonstrated the ability to maintain order and engagement during periods without formal instruction.

The facility also supported youth engagement through religious accommodations, including the provision of garments and support for Eid-related activities. Incentive structures, such as “Unit of the Week,” were implemented to promote accountability and positive behavior.

Additionally, OCO observed collaboration between facility staff and external partners in responding to youth requests and addressing concerns. The facility demonstrated responsiveness in initiating maintenance requests and engaging in environmental testing.

During the reporting period, a youth at VCC successfully earned a high school diploma. This achievement reflects both individual effort and staff support and demonstrates the facility’s capacity to produce positive outcomes when structure and engagement are aligned.

Graduation Day



Recommendations

OCO recommends the following actions to address identified concerns and support continued progress:

1. Discontinue use of the school trailer for instruction and transition to a safe, permanent educational environment
2. Ensure environmental remediation and air quality practices align with established health and safety standards prior to re-occupancy
3. Improve timeliness and consistency of maintenance repairs, including plumbing, lighting, and water systems
4. Ensure access to safe drinking water and functional facilities at all times
5. Reinforce adherence to use-of-force policies and ensure alignment between incident reports and video evidence
6. Prohibit youth involvement in restraint situations and reinforce staff training accordingly

7. Expand structured programming and workforce development opportunities, including reinstatement or replacement of suspended programs
8. Improve case management access and communication regarding youth status and progression
9. Reinforce SB 134 protections and ensure youth can report concerns without fear of retaliation
10. Maintain and build upon positive practices that contributed to reductions in incidents and improved outcomes

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/pages/facilities/backbone-mountain-youth-center.aspx>

Backbone Mountain Youth Center – Selected Incident Categories	FYQ3 2024	FYQ3 2025	FYQ3 2026
Average Daily Population (ADP)	25	24	18
1. Youth on Youth Assault/Fight	11	20	6
2. Alleged Youth on Staff Assault	1	11	0
3. Physical Restraint	37	57	18
4. Use of Handcuffs and/or Shackles	9	11	1
5. Seclusion	1	1	0
6. Contraband	1	9	3
7. Suicide Ideation	1	4	4
8. Suicide Attempt	0	0	0
9. Self-Injurious Behavior	0	0	0

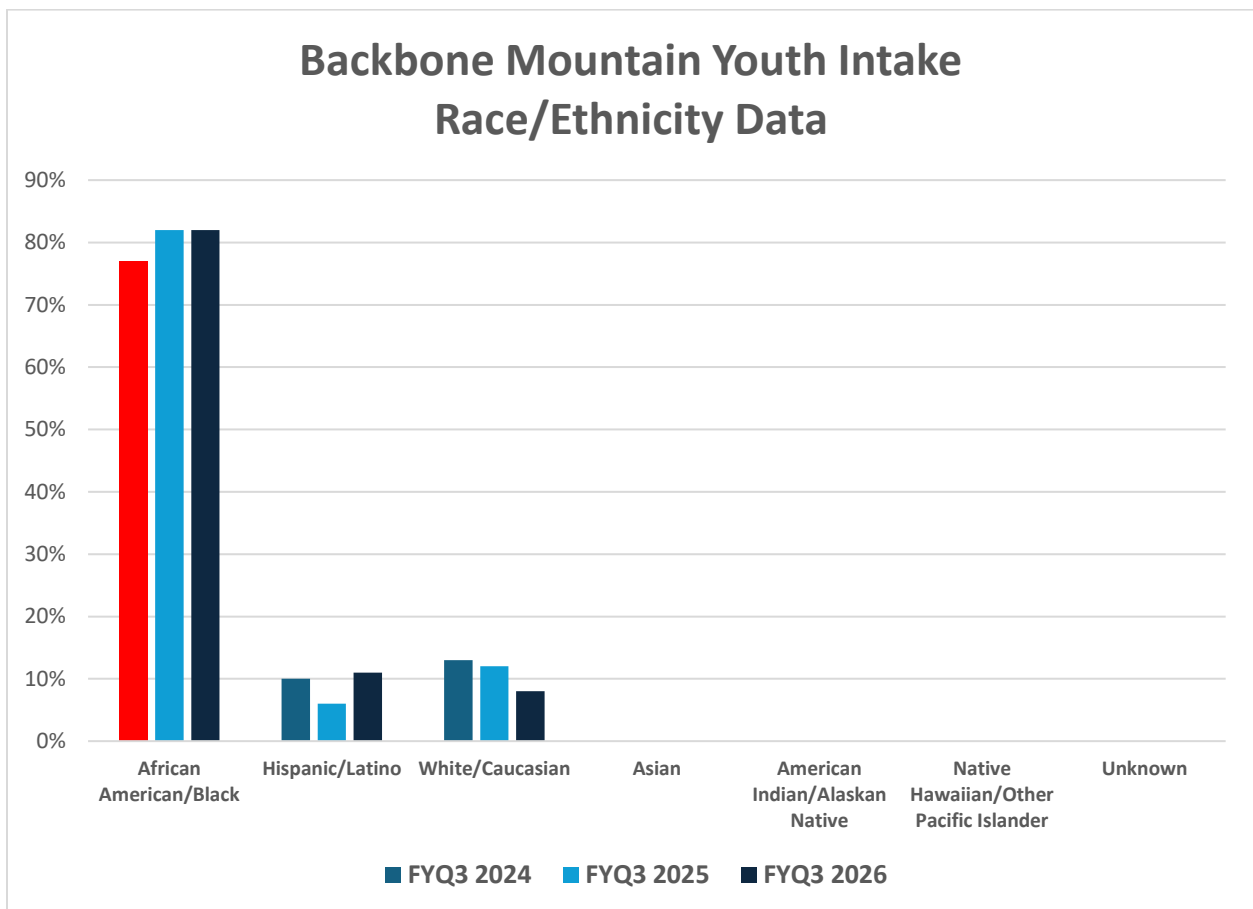
Data Highlights from DJS database

Backbone Mountain Youth Center demonstrated substantial reductions in both population and reported incident activity during FYQ3 2026.

- Average Daily Population (ADP) decreased to 18
- Reported youth-on-youth assaults decreased by 70%

- Alleged youth-on-staff assaults decreased from 11 to 0
- Reported incidents involving Physical restraints decreased by 68%
- Mechanical restraints decreased by 91%
- Seclusion was not utilized during the quarter
- Contraband incidents decreased
- Suicide ideation remained stable, with no suicide attempts or self-injurious behavior reported

These trends reflect meaningful improvements in facility safety, behavior management, and overall operational stability.



Facility Overview and Operations

Backbone Mountain Youth Center (BMYC) is a staff-secure placement facility serving committed male youth. During the third quarter of FY2026, the facility demonstrated significant improvements across key safety and operational indicators, alongside a notable reduction in population.

The Average Daily Population (ADP) decreased to 18, down from 24 in FY2025 and 25 in FY2024. This reduction in population coincided with substantial decreases in incident activity. Youth-on-youth assaults declined by approximately 70 percent, and alleged youth-on-staff assaults decreased from 11 incidents in FY2025 to zero during the current reporting period. The use of physical restraints decreased significantly, and the use of mechanical restraints was minimal. Seclusion was not utilized during the quarter.

Contraband incidents decreased, and while suicide ideation remained present, there were no reported suicide attempts or incidents of self-injurious behavior.

These trends reflect meaningful progress in facility safety, behavior management, and overall operational stability. The reduction in both population and incidents suggests that the facility is maintaining a controlled and structured environment with reduced reliance on high-level interventions.

Facility Climate, Staff Engagement, and Youth Experience

During the reporting period, BMYC maintained a consistently stable and structured environment, supported by strong staff presence and engagement.

Youth consistently reported feeling safe within the facility and described generally positive relationships with staff. Youth indicated that their basic needs were being met and that they had access to services and support. Many youth also reported growth in areas such as decision-making, accountability, and personal responsibility.

Youth approaching release demonstrated a clear sense of direction and readiness, including planning for next steps and engagement in programming. These observations suggest that youth are benefiting from the structured environment and are internalizing key skills associated with successful transition.

Staff were observed to be responsive and engaged, and supervision remained consistent throughout the quarter. Even during periods of staffing challenges or call-outs, the facility maintained structure and continuity in operations.

Programming, Recreation, and Youth Engagement

BMYC continues to demonstrate strong implementation of structured and incentive-based programming. Youth had consistent access to recreational opportunities, including gym activities and outdoor programming.

A notable feature of programming at BMYC is the use of incentive-based engagement. Activities such as skiing and snowboarding were used as behavioral incentives, reinforcing positive conduct and participation. Special events, including Super Bowl programming, further contributed to youth engagement and morale.

Despite occasional staffing limitations, programming remained consistent, and youth participation remained high. These efforts contributed to maintaining stability and reducing idle time, which is often a contributing factor in behavioral incidents.

Overall, programming at BMYC reflects a strength of the facility and plays a key role in supporting positive youth development.

Safety, Supervision, and Operational Stability

Facility operations remained stable throughout the reporting period. There were no major safety incidents reported, and staff maintained appropriate supervision and control across housing units.

During a January 30, 2026 check-in, facility leadership confirmed that there were no HVAC or heating concerns and no significant physical plant issues impacting safety or operations at that time. Staff presence remained consistent, and the facility demonstrated the ability to maintain structure even during temporary staffing fluctuations.

The overall reduction in reported incidents, combined with stable operations and consistent supervision, indicates that BMYC is functioning as an effective staff-secure placement environment.

Food Service and Environmental Health

While overall facility operations were stable, OCO identified concerns related to food service and kitchen operations.

During site visits, OCO observed that some food items were not properly labeled or dated, and there were instances of spoiled or degrading food products present. Additionally, a kitchen oven had been out of service for an extended period, impacting food preparation capabilities.

Staff responded appropriately during the visit by removing expired items and acknowledging the need for improved practices. However, these findings indicate the need for more consistent adherence to food safety protocols, including proper labeling, storage, and routine monitoring.

Continued oversight is necessary to ensure that food service operations meet required standards and that corrective actions are sustained.

Physical Plant and Maintenance

OCO identified several maintenance-related concerns during the reporting period. While none were identified as immediately hazardous, these issues impact daily operations and overall quality of life.

Observed concerns included a deteriorating concrete walkway that affected door functionality, as well as shower-related issues such as inconsistent hot water and signs of structural wear. Graffiti was observed within cabin areas, and delays in repairing kitchen equipment were noted.

Additionally, OCO identified a lack of camera coverage in the commissary area. While broader facility camera coverage appeared functional, the absence of monitoring in this area presents a gap in oversight and accountability.

These findings highlight the need for timely maintenance, routine inspections, and proactive planning to address infrastructure issues before they escalate.

Deteriorating Concrete



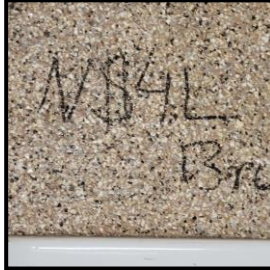
Damaged Shower



Damaged Shower



Graffiti



Youth Basic Needs

OCO observed concerns related to youth personal property, specifically footwear. Some youth were observed wearing worn or damaged shoes.

Follow-up confirmed that replacement items were provided; however, this issue underscores the importance of proactive monitoring to ensure that youth basic needs are consistently met. Timely replacement of essential items such as clothing and footwear is necessary to maintain dignity, comfort, and overall well-being.

Damaged Shoe



Damaged Shoe



Damaged Shoe



Overall Assessment

Backbone Mountain Youth Center demonstrated progress during FYQ3 2026, particularly in reducing incidents, limiting the use of force, and maintaining a stable and structured environment.

Key strengths include strong staff-youth relationships, effective programming, and consistent supervision. Youth engagement remains high, and the facility continues to support positive behavioral development and readiness for transition.

At the same time, areas requiring continued attention include food service compliance, maintenance and infrastructure, camera coverage, and proactive monitoring of youth basic needs.

Overall, BMYC is operating as a stable and well-functioning staff-secure placement facility, with opportunities to strengthen consistency in operational and environmental practices.

Recommendations

1. OCO recommends the following actions to support continued progress and address identified concerns:
2. Continue and reinforce strategies that contributed to reductions in incidents, including structured programming and staff engagement
3. Ensure full compliance with food safety protocols, including proper labeling, storage, and timely removal of expired items
4. Address maintenance and infrastructure issues promptly, including showers, walkways, and kitchen equipment
5. Install camera coverage in the commissary area to improve safety, accountability, and oversight
6. Implement routine monitoring of youth basic needs, including clothing and footwear, with timely replacement
7. Maintain adequate staffing coverage and contingency planning to sustain operational stability
8. Sustain and expand incentive-based programming and recreational opportunities to support continued youth engagement

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-ridge-youth-center.aspx>

Green Ridge Youth Center– Selected Incident Categories	FYQ3 2024	FYQ3 2025	FYQ3 2026
Average Daily Population (ADP)	24	24	16
1. Youth on Youth Assault/Fight	35	10	3
2. Alleged Youth on Staff Assault	3	17	1
3. Physical Restraint	72	121	18
4. Use of Handcuffs and/or Shackles	3	47	0
5. Seclusion	0	0	1
6. Contraband	2	6	3
7. Suicide Ideation	18	28	5
8. Suicide Attempt	0	0	0
9. Self-Injurious Behavior	0	0	0

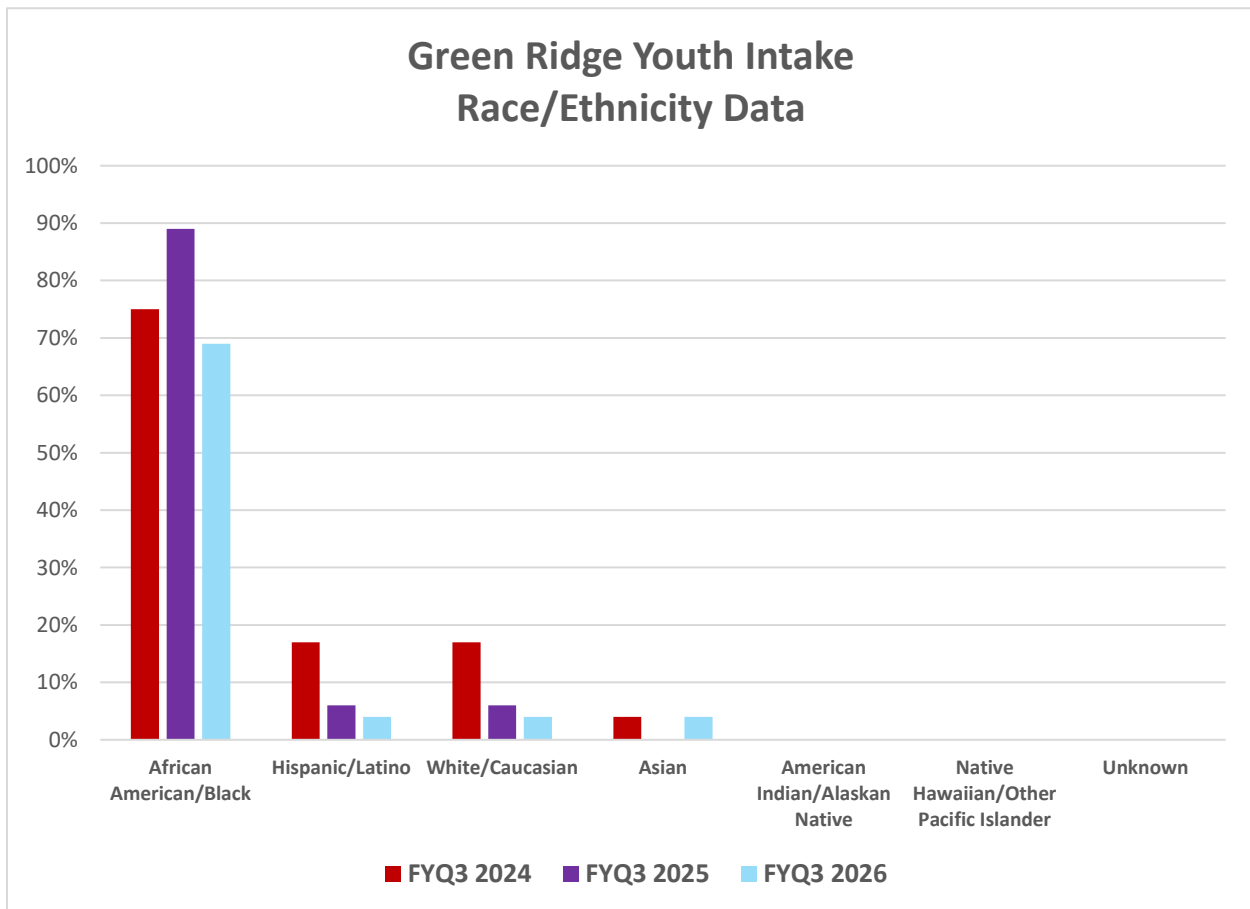
Data Highlights from DJS database

Green Ridge Youth Center demonstrated substantial improvement during FYQ3 2026, particularly when compared to the instability observed during FYQ3 2025.

- Average Daily Population decreased from 24 to 16
- Youth-on-youth assaults decreased from 10 to 3
- Alleged youth-on-staff assaults decreased from 17 to 1

- Incidents involving physical restraints decreased significantly from 121 to 18
- Mechanical restraints decreased from 47 to 0
- Suicide ideation decreased from 28 to 5
- Contraband incidents decreased slightly
- No suicide attempts or self-injurious behavior were reported

These reductions reflect a significant shift toward improved stability, safety, and behavior management.



Facility Overview and Operations

Green Ridge Youth Center (GRYC) is a staff-secure placement facility serving committed male youth. During the third quarter of FY2026, the facility demonstrated improvement across key operational and safety indicators, particularly when compared to the instability observed during FY2025.

The Average Daily Population (ADP) decreased from 24 to 16, reflecting a notable reduction in the number of youth served during the reporting period. This decrease in population

corresponded with significant reductions in incident activity. Youth-on-youth assaults declined from 10 to 3, and alleged youth-on-staff assaults decreased from 17 to 1. The use of physical restraints dropped from 121 incidents to 18, while the use of mechanical restraints was eliminated entirely. Incidents involving suicide ideation decreased from 28 to 5, and no suicide attempts or self-injurious behavior were reported.

These trends reflect a meaningful shift toward improved stability, safety, and behavior management within the facility.

Facility Climate, Staff Engagement, and Youth Experience

Across site visits and check-ins, GRYC maintained a calm, structured, and stable environment. Staff consistently attributed improvements in facility climate to increased staff stability, reduced reliance on overtime, and the implementation of consistent daily structure supported by trauma-informed approaches.

Youth were observed actively engaged in programming and interacting across groups in a manner more consistent with a community-based placement model in contrast to a traditional detention setting. Interactions between staff and youth appeared appropriate, and the overall tone of the facility reflected improved cohesion and predictability.

The observed environment suggests that both staff and youth are benefiting from a more stable operational structure, contributing to reductions in incidents and improved day-to-day functioning.

Youth Engagement, Recreation, and Family Involvement

GRYC demonstrated strong performance in youth engagement and enrichment programming during the reporting period. Youth had access to a variety of structured activities designed to promote positive development, engagement, and social connection.

Programming highlights included regular off-grounds trips, such as visits to the National Museum of African American History and Culture and Gettysburg, as well as recreational opportunities including skiing, snowboarding, and organized tournaments such as Madden competitions. The facility also hosted a family engagement event with strong participation, further strengthening connections between youth and their support systems.

Youth participation in structured activities, including the CHAMPS oratorical competition and graduation-related events, reflected a focus on achievement, communication skills, and personal growth.

These efforts demonstrate a strong emphasis on positive youth development, family engagement, and exposure to pro-social and educational experiences, all of which are critical components of successful rehabilitation.

Education and Vocational Programming

GRYC made progress in enhancing educational access and programming. The rollout of tablets supported increased access to educational resources, and youth were engaged in certificate-based

learning and resume-building activities. Classroom upgrades, including new desks and equipment, further contributed to an improved learning environment.

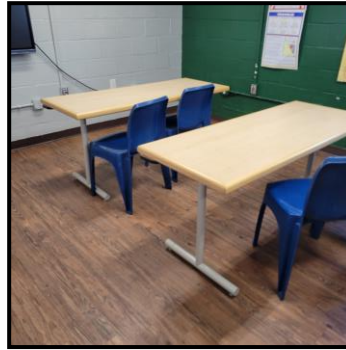
However, the full implementation of the construction and vocational program remains delayed. Identified barriers include procurement challenges, technology limitations, lack of finalized tool control procedures, and gaps in equipment and safety supplies. These delays limit youth access to meaningful workforce development opportunities that are critical for successful reentry.

Continued focus on resolving these barriers is necessary to ensure that vocational programming aligns with the facility's broader goals of skill development and transition readiness.

Damaged Desk



New Desks



Physical Plant and Maintenance

GRYC demonstrated responsiveness in addressing maintenance concerns identified during site visits. Several issues were resolved during the reporting period, including bathroom and shower repairs, replacement of a vent cover, and upgrades to classroom furniture. Restroom renovations were also nearing completion.

The facility's responsiveness to maintenance concerns reflects improved accountability and follow-through by DJS. While no significant or systemic physical plant concerns were identified during the quarter, continued proactive maintenance will be important to sustain these improvements and ensure a safe and functional environment.

New Drain and Floor



New Shower



Degrading Food



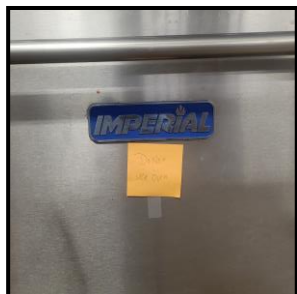
Unlabeled Food



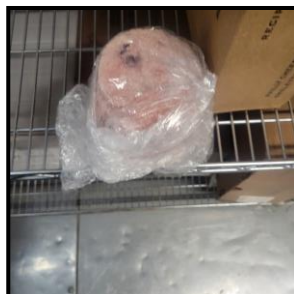
Unlabeled Food



Oven Out of Service



Unlabeled Food



Unlabeled Food



Medical Services and Oversight

OCO identified concerns related to medical staffing and medication oversight during the reporting period. The facility operated with one nurse covering weekday operations, with limited supervisory presence and reliance on on-call coverage during after-hours periods.

Additionally, two medication errors involving Certified Medication Technicians (CMTs) were reported. While no harm resulted from these incidents, they raise concerns regarding staffing adequacy, oversight of medication administration, and the effectiveness of quality assurance processes.

These findings suggest a need for enhanced supervision, training, and monitoring to ensure that medical services are delivered safely and consistently.

Food Service Compliance

During site visits, OCO observed issues related to food service compliance, including unlabeled and undated food items and improper storage practices. Staff addressed these issues promptly during the visit; however, the observations indicate a need for consistent adherence to food safety protocols.

Ongoing monitoring is necessary to ensure that proper labeling, dating, and storage practices are maintained and that corrective actions are sustained over time.

Leadership and Operational Continuity

During the start of the reporting period, GRYC operated without a permanent Superintendent or Assistant Superintendent. A new Superintendent with experience in facility leadership was hired in February 2026. Sustained leadership is critical to maintaining the progress achieved during this quarter and ensuring that operational improvements are institutionalized.

Overall Assessment

Green Ridge Youth Center demonstrated improvements during FYQ3 2026, particularly when compared to the instability observed in the prior year. The facility has made measurable progress in reducing incidents, limiting the use of force, and establishing a more stable and structured environment.

Key strengths include strong youth engagement, effective programming, positive family involvement, and improved responsiveness to maintenance and operational concerns. The overall facility climate reflects a shift toward a more youth-centered and developmentally appropriate model.

At the same time, continued attention is needed in areas such as medical staffing and oversight, vocational program implementation, food service compliance, and leadership continuity.

Overall, GRYC is operating in a more stable, structured, and positive manner, with continued progress dependent on sustained leadership and consistent operational practices.

Recommendations

OCO recommends the following actions to support continued progress and address identified concerns:

1. Conduct a medical staffing assessment to ensure adequate coverage and supervisory oversight
2. Strengthen medication administration protocols, including ongoing CMT training and quality assurance review
3. Reinforce staff understanding of OCO authority under SB 134, including access to and duplication of records
4. Maintain and monitor food service compliance, including labeling, dating, and storage practices
5. Sustain timely response to maintenance issues and continue proactive facility upkeep
6. Prioritize full implementation of vocational programming, including tool control procedures and equipment procurement
7. Continue expanding youth engagement opportunities, including off-grounds activities and family programming
8. Monitor educational services to ensure consistent access and appropriate support for all youth
9. Ensure a stable leadership structure to support long-term accountability and operational consistency

Individual Facility Reports: Smaller Programs

Morning Star Youth Academy

Facility Description:	DJS-Licensed Staff Secure (not locked and fenced) Placement Center
Population Served:	Committed Male Youth Ages 13 to 18
Location:	Eastern Shore, Maryland (Woolford, MD)
Rated Capacity:	Licensed for 24 Youth
Operated By:	VQ https://www.vq.com/by-state/maryland#morning-star

Facility Overview and Operations

Morning Star Youth Academy is a CARF-accredited, DJS-licensed staff-secure placement that operates in a community-based setting. The program serves committed male youth and utilizes a trauma-informed approach grounded in Trust-Based Relational Intervention (TBRI), along with elements of the Sanctuary Model, to promote safety, emotional regulation, and positive youth-staff relationships.

The facility maintains a low staff-to-youth ratio of approximately 1:3 during waking hours, allowing for individualized attention and increased engagement. Therapeutic services are provided both on-site and through community-based providers, and the program leverages local partnerships to expand access to enrichment, employment, and recreational opportunities.

Education services are delivered through Dorchester County Public Schools via virtual instruction, with on-site educational support available to assist youth. The facility is also working toward compliance with the Prison Rape Elimination Act (PREA), with a targeted completion date of August 2026.

Population and Incident Overview

During the reporting period, nine youth were placed at Morning Star Youth Academy. Two youth were successfully discharged, and one youth was released by the court after approximately eight months in placement.

Consistent with smaller licensed facilities, incident activity remained relatively low. Two notable incidents occurred during the quarter, including one restraint and one youth-on-youth altercation, both of which took place in the gymnasium.

OCO requested to review video footage associated with these incidents; however, the facility reported that camera transmission issues prevented footage from being recorded in the gym. The inability to review video footage in the gym presents a significant concern related to accountability and incident review. In response, administration indicated that corrective actions are underway, including hardwiring cameras and improving internet connectivity. The gym was temporarily taken out of service for youth use until these issues are resolved.

Facility Climate, Programming, and Youth Engagement

Morning Star continues to provide a structured yet community-based environment that emphasizes relationship-building, therapeutic engagement, and positive youth development. Youth regularly participate in off-site activities, including recreational outings, religious services, volunteer opportunities, and employment where appropriate.

The program's model supports a more normalized environment compared to traditional secure settings, and youth are provided with opportunities to engage with the community in a meaningful way. Observations indicate that the low staff-to-youth ratio and therapeutic approach contribute to a supportive and individualized environment.

Wellness and Therapeutic Services

The facility has expanded its wellness and therapeutic programming through a partnership with Life's Energy Wellness Center, a local Psychiatric Rehabilitation Program. Through this partnership, youth have participated in services such as yoga, sound baths, and psychoeducational groups.

These offerings reflect a holistic approach to care, supporting both mental health and emotional well-being. The integration of community-based therapeutic services enhances the program's ability to meet the diverse needs of youth in placement.

Re-Entry Planning and Transition Support

Morning Star has demonstrated a proactive approach to re-entry planning, particularly in addressing a common barrier faced by youth transitioning out of placement: lack of essential identification documents.

Facility administrators have taken steps to ensure that youth are discharged with critical documentation, including birth certificates and Social Security cards. The program also assists eligible youth in obtaining state identification cards and learner's permits.

This level of preparation is essential for successful re-entry, as it supports youth access to employment, education, housing, and other critical services upon release.

Physical Plant and Maintenance

Morning Star has made meaningful investments in improving the physical environment. Renovations to the welcome center and administrative building have been completed, and the youth living quarters were renovated and opened during the quarter. The updated living space provides a more comfortable, home-like setting that aligns with the program's therapeutic model.

Despite these improvements, some outstanding maintenance needs remain. A school window that has been broken for an extended period has not yet been replaced. Although replacement windows have been delivered and are on-site, installation has not been completed.

Continued attention to routine maintenance and timely completion of repairs will be important to sustain improvements in the physical plant.

Youth Living Quarters



Living Room



Bed Room



Shower



Broken Window



Overall Assessment

Morning Star Youth Academy continues to operate as a therapeutic, community-based placement that emphasizes individualized care, relationship-building, and positive youth development. The program's low staff-to-youth ratio, use of trauma-informed models, and integration of community resources contribute to a supportive environment for youth.

Strengths of the program include strong therapeutic engagement, meaningful community-based programming, and proactive re-entry planning. Facility leadership has also demonstrated a commitment to improving the physical environment and expanding wellness services.

At the same time, concerns remain regarding camera functionality as well as the need to complete outstanding maintenance items. Addressing these areas will be important to ensure continued accountability and safety.

Recommendations

OCO recommends the following actions to support continued progress and address identified concerns:

1. Ensure gym cameras are fully functional, properly recording, and capable of retaining footage for incident review
2. Maintain the restriction on gym use until camera functionality is restored and verified

3. Continue planned upgrades to the physical plant, with priority given to outstanding maintenance needs such as window installation
4. Sustain and expand therapeutic and wellness programming through community partnerships
5. Continue proactive re-entry planning efforts to ensure youth are discharged with essential identification and documentation

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/>

Facility Overview and Operations

One Love Group Home is a DJS-licensed residential placement operated by Building Communities Today for Tomorrow, Inc., a community-based organization located in Baltimore City. The program serves up to eight male youth ages 16 to 20, including youth committed through the Maryland Department of Juvenile Services and those in the care of the Baltimore City Department of Social Services.

The home is situated within a residential neighborhood and is designed to provide a supportive, home-like environment. Youth attend local community schools, and those who have completed high school are supported in obtaining employment within the surrounding community. Residents are provided access to recreational opportunities, including memberships to a local YMCA, and staff coordinate regular outings to support enrichment and social development.

Therapeutic and medical services are delivered through community-based providers, allowing youth to access services within the broader community setting.

Unlike more structured residential programs, One Love operates with a less intensive model, offering a higher degree of independence for youth. As a result, the program is best suited for young people who are more mature, self-motivated, and capable of managing increased personal responsibility.

Population and Incident Overview

During the reporting period, three youth were placed at One Love through DJS.

Consistent with other small, community-based placements, incident activity remained low. There were no incidents of concern reported during the quarter.

Facility Climate and Youth Experience

One Love provides a calm and supportive environment for youth. The home-like setting and integration into the community allow youth to experience a level of normalcy that supports their transition toward independence.

Youth are afforded opportunities to attend school, work, and engage in recreational and community-based activities. This structure supports the development of life skills, responsibility, and self-sufficiency. The program's approach aligns with a transitional model, preparing youth for independent living.

Case Management and Coaching Support

While the program provides a supportive environment, it does not offer intensive case management or structured life-skills programming. As a result, youth at One Love would benefit from additional support from DJS community case managers and external partners to help guide their educational and career development.

During the reporting period, one youth secured part-time employment through DoorDash and overnight work at Home Depot. He expressed interest in pursuing a trade, specifically auto repair, as a pathway to more stable and sustainable employment. Through coordination with his DJS community case manager, he was connected to a trade program where he can work toward certification.

Another youth expressed interest in attending college and pursuing a career in the healthcare field. This youth would benefit from structured support in navigating the college application process, accessing financial aid, and identifying appropriate academic programs.

These examples highlight both the motivation of youth placed at One Love and the need for more structured guidance to help them translate their goals into achievable outcomes.

Overall Assessment

One Love Group Home continues to operate as a stable, community-based placement that provides a supportive and home-like environment for youth transitioning toward independence. The program's strengths include low incident activity, integration into the community, and opportunities for youth to engage in school, employment, and recreational activities.

The program is particularly effective for youth who are self-motivated and capable of managing a higher level of independence. However, the limited structure and absence of intensive case management services create gaps in support for youth who require more guidance in achieving long-term educational and career goals.

Strengthening coordination with DJS and community partners will be critical to ensuring that youth placed at One Love are fully supported in their transition to adulthood.

Recommendations

OCO recommends the following actions to enhance support for youth at One Love:

1. Strengthen coordination between One Love staff, DJS community case managers, and community partners to provide more structured support around education and career planning
2. Continue to connect youth to employment opportunities while prioritizing pathways that support long-term career development and financial stability

3. Expand access to structured guidance for college readiness, trade programs, and certification opportunities
4. Ensure that youth receive consistent support in accessing financial aid, workforce development programs, and post-secondary education resources

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/pages/facilities/hickey-structured-shelter-care-program.aspx

Data Highlights from DJS database

- Average daily population was 4 youth

Facility Overview and Operations

The Charles H. Hickey, Jr. School Shelter Program (Hickey Shelter) operates as short-term housing for youth awaiting court disposition or transition to longer-term placement. The program serves a small population and is designed to provide temporary stabilization and supervision during transitional periods.

Facility operations during site visits throughout the quarter appeared stable, and staff demonstrated the ability to maintain a calm and controlled environment.

Youth reported no immediate safety concerns, and living areas were observed to be clean and well-maintained. Direct care staff were consistently engaged, providing strong supervision and responding appropriately to youth needs. The overall tone of the facility reflects a stable environment aligned with its intended purpose as a short-term placement.

Facility Climate and Daily Structure

While the facility maintained a stable environment, gaps were identified in daily structure, particularly during school hours. Youth not enrolled in school were observed watching television for extended periods during the day, with limited access to structured programming or meaningful activities.

Although supervision was present, the lack of structured daytime programming resulted in excessive downtime and missed opportunities for academic engagement and skill development.

The absence of a structured schedule for youth not yet enrolled in school limits the program's ability to fully support youth during a critical transitional period.

Education and Service Gaps

While some youth were actively attending school, others were not yet enrolled and were not consistently receiving instruction or participating in structured academic programming.

Staff provide transportation and support once enrollment is established; however, gaps exist prior to that point. Youth awaiting enrollment are not engaged in educational activities. This gap highlights the need for interim educational programming and structured learning opportunities to ensure that youth remain engaged academically during their time at the shelter.

Youth Needs and Behavioral Health

The Hickey Shelter serves youth with varying levels of need, including those transitioning from secure detention and youth with significant cognitive or behavioral health challenges.

During the reporting period, one youth presented with notable cognitive delays and mental health needs, including difficulty processing information and communicating effectively. This youth required a higher level of supervision and support than is typically provided in a Shelter setting. The Shelter staff are commended for maintaining this youth giving his clinical limitations.

While the Shelter functioned as an appropriate temporary placement, this youth requires a more specialized clinical placement. This situation reflects a broader system challenge related to the limited availability of appropriate placements for high-needs youth, resulting in temporary placements that may not fully align with the youth's level of care needed.

Case Management and Staff Engagement

Direct care staff were consistently present and engaged with youth; however, case management presence during program hours appeared limited. Reports indicated that case managers were often not actively engaged with youth during periods of downtime, with much of their time spent in their office with the door closed.

This limited interaction represents a missed opportunity to support youth through individualized engagement, goal setting, and transitional planning. OCO has previously raised concerns regarding the need for greater integration of case management into daily programming.

Increased visibility and engagement from case management staff would enhance the overall effectiveness of the program and provide youth with additional support during their stay.

Physical Plant and Maintenance

A maintenance issue was identified that impacts daily operations and youth access to essential hygienic grooming. Specifically, the shower nozzle requires replacement, and water temperature has been reported as inconsistent. As a result, male youth have occasionally utilized female showers which disrupts normal operations and creates potential concerns related to appropriate separation and privacy. Staff reported that a work order has been submitted to address the issue.

While this issue does not present an immediate safety risk, timely repair is necessary to restore normal facility operations.

Male Shower



Overall Assessment

The Hickey Shelter provided a stable environment with strong direct care staff supervision and engagement. Youth basic needs are generally being met, and the facility maintains a clean and orderly environment.

However, several key gaps limit the program's effectiveness. These include a lack of structured daytime programming, educational access for youth awaiting enrollment, limited case management engagement, and challenges in securing appropriate placements for youth with higher levels of need. Additionally, maintenance issues, while minor, impact daily operations and should be addressed promptly.

Addressing these areas will strengthen the shelter's ability to provide consistent structure, support youth development, and better meet the needs of youth during transitional periods.

Recommendations

1. Provide structured academic and enrichment activities during school hours for youth awaiting enrollment
2. Ensure case managers are actively present and engaged with youth during program hours
3. Reduce idle time by implementing consistent daily schedules with meaningful activities
4. Expedite placement for youth requiring specialized clinical care and ensure assessments guide placement decisions
5. Complete shower repairs to restore proper function and maintain appropriate separation
6. Continue strong supervision and engagement practices demonstrated by direct care staff

