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

SPECIAL REPORT
THOMAS J.S. WAXTER CHILDREN'S CENTER
FINAL FINDINGS AND RECOMMENDATIONS

March 22, 2007

The Honorable Donald W. DeVore
Secretary, Department of Juvenile Services
One Center Plaza
120 W. Fayette Street
Baltimore, MD 21201

Re: Thomas J.S. Waxter Children's Center
Special Report

Dear Secretary DeVore:

We are in receipt of the Department of Juvenile Services responses to our Special Report on Thomas J.S. Waxter Children's Center dated March 22, 2007. These responses have been appended to our Final Findings and Recommendations.

Our agencies' Memorandum of Agreement (MOA) provides a 45-day period following issuance of a report for development of a Corrective Action Plan. This plan should include corrective actions already taken by the Department of Juvenile Services and any future actions planned "including timelines for completion."

"To enhance the possibility of agreement as to the Corrective Action Plan," our MOA also requires that the Juvenile Justice Monitoring Unit and the Department of Juvenile Services "engage in discussions concerning…(the) proposed Corrective Action Plan" during this time period.

As the deadline for development of a Corrective Action Plan is April 26, 2007, we would like to schedule the first of these meetings at your earliest convenience. I look forward to hearing from you and to continuing to work with you and your staff and to ensure the safety of children currently housed at the Waxter Children's Center.

Respectfully submitted,

Marlana R. Valdez
Director
Juvenile Justice Monitoring Unit

Enclosure

Cc: The Honorable Thomas V. Miller, Jr., President of the Senate
The Honorable Michael E. Busch, Speaker of the House of Delegates
Arlene F. Lee, Executive Director, Governor's Office for Children
Katherine Winfree, Chief Deputy Attorney General, Office of the Attorney General

Electronic Copies: Roberto "Tito" Rodriguez, Deputy Secretary, DJS
James Smith, Assistant Secretary, DJS
Phillip O'Donnell, Director, OPRA, DJS
Robert Fontaine, Principal Counsel, DJS
Marian Daniel, Program Manager, DJS

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FINAL FINDINGS AND RECOMMENDATIONS

Facility:	Thomas J. S. Waxter Children's Center 375 Red Clay Rd. Laurel, Md. 20724 Superintendent: Ms. Janice Gardener Phone: 410-792-7416
Date of Investigation:	January 23 – March 2, 2007
Reported by:	Claudia Wright
Issues Reported:	Threat to Life, Health, and Safety of Staff and Youth ➢ Inadequacy of physical facility ➢ Improper use of seclusion ➢ Staffing shortage and insufficient staff training
Date of Report:	March 22, 2007

EVIDENTIARY BASIS FOR REPORT

Documents Reviewed

- Maryland State Police Report CIR-0765000821 (01-22-07)
- Maryland State Fire Marshal Facility Inspection Records, Waxter Children's Center (2006)
- Waxter Children's Center Seclusion Admission Log (1-1-07 through 2-27-07)
- Letter, Deborah St. Jean, Office of the Public Defender, to James Smith, Department of Juvenile Services (1-22-07)
- Maryland State Health Inspection Records (2006)
- Incident Reports (DJS OPRA) (Jan/Feb, 2007)
- Witness Statements (DJS OPRA) (Jan/Feb, 2007)
- Daily Population sheets (Jan/Feb, 2007)
- Individual seclusion files including door sheets (18)(Jan/Feb, 2007)

Persons Interviewed

Waxter Children's Center Administrative Staff (2)
Waxter Children's Center Direct Care Staff (5)
Waxter Children's Center Youth (9)

STANDARDS APPLIED

Maryland Department of Juvenile Services Standards for Juvenile Detention Facilities

- 5.1.3 – Staffing
- 5.1.2.4 – Key and Equipment Control
- 6.2.3 – Facility design; internal design and appearance
- 6.6 – Facility design; environmental conditions

Maryland Department of Juvenile Services Policies

- Limits on Use of Restraints and Seclusion (03.14.04 IV)
- Policy on Seclusion (RF-01-07)(January, 2007)

American Correctional Association Standards for Juvenile Detention Facilities

- Emergency Plans (Standard 3-JDF-3B-12. 3)
- Juvenile Housing (Standard 3-JDF-2C-03)

INTRODUCTION

The Thomas J.S. Waxter Children's Center (the "Waxter Center") is a state owned and operated detention/residential treatment facility housing girls under the age of 18. The Waxter Center includes one detention unit, one pending placement unit and one secure committed program. The Waxter Center is operated under the Department of Juvenile Services Standards for Juvenile Detention Centers and other DJS policies and procedures. The stated maximum population of the Center is 41.

Although different areas of the building are designated for the three groups, detention and pending placement girls are frequently moved between the "B" (detention) unit and "C" (pending placement) unit based on practical considerations such as behavior, vulnerability, size, and age. The "B" unit is located off the central hallway of the building. The "B" unit dayroom is entered through two sets of manually locked doors, with a small sally-port area between the doors. On the far side of the day room, a long hallway is lined with individual, manually locked rooms. A small dormitory is located at the end of the hallway. The "C" unit is essentially one large dormitory room on the other side of the building.

Girls in the secure committed program live in the "A" unit, and rarely intermingle with the detention and pending placement girls.

PRECIPITATING INCIDENTS

1. On January 22, 43 girls were assigned to the program – 9 in pending placement, 9 in the secure committed program, and 25 in detention.

   At approximately 6:45 pm, "B" unit girls were in the cafeteria area. Pursuant to the Waxter Center's behavior modification system, some girls were eligible for and were receiving candy from the canteen cart. Some girls were not eligible based on their "points", but if the staff on duty felt they had exhibited good behavior during the day, they also received candy.

   The girls who were not receiving candy became agitated, entered the kitchen area, and took candy from the cart. The youths who took the candy were searched, the candy was taken away, and the girls were returned to the "B" unit.

   (At least one other incident had occurred earlier in the day – the water fountain in the "B" unit dayroom had been torn from its moorings and flooded. It is not clear whether this incident contributed to the agitation of the youth. It is clear that there was a high degree of agitation among the children as the afternoon and evening wore on.)

   At that point there were approximately 20 girls and 2 staff present in the "B" unit dayroom. Several girls participated in setting off the fire sprinklers and flooding the "B" unit, outside hallway and other areas of the building. One staff member had to go outside the building to attempt to turn off the water. The girls were playing in the water, taking off their clothes, dancing and slapping each other with their wet clothes. Ceiling tiles were pulled down, and a light fixture was pulled

down. Staff reported that upon seeing sparks flying from the lighting fixture they feared that if the fixture went into the water someone could be electrocuted. At that point, because the “B” unit was not safe, the residents were returned to the cafeteria.

The girls, drenched from the water, began again to remove their wet clothes, dance around, and slap each other with the wet clothes. The State Police were called and arrived on the scene to attempt to restore order. The Fire Department also arrived on the scene to inspect the fire sprinklers and return them to working order.

Waxter Center staff members were unable to control the situation without the intervention of the police. This statement is corroborated by statements taken from various staff and youth who were witnesses and participants in the events described.

Upon the arrival of the State Police, some of the girls were returned to the flooded “B” unit. Other residents remained in the cafeteria, and some were taken to the tour office. The residents who were returned to the “B” unit were ordered by State Police and staff to re-enter their rooms. The rooms were still wet from the flooding. One girl refused to re-enter her room, and she was sprayed with pepper spray by the State Police officer to force her to comply.

According to facility logs, 12 girls were then held in locked seclusion in their rooms for as long as 48 hours. The administration reported that the cleanup effort continued until early the next morning.

2. On February 5, 2007, 7 girls were held in locked seclusion for up to 48 hours following an altercation in the outside recreation area.

3. On February 7, 3 girls were held in secure seclusion for 48 hours following a fight during a presentation in the dayroom.

4. On February 13, 10 girls were held in locked seclusion for 48 hours following a group altercation on the “B” unit that lasted approximately 5 minutes. A number of girls received injuries that required medical attention.

5. On March 5 and 6, 10 more seclusions were authorized in response to fighting among the youth.

KEY FINDINGS

These precipitating events illustrate a number of safety hazards at the Waxter Center, ranging from the relative ease with which residents can flood large areas of the facility to potential electrocution. These factors coupled with multiple difficulties with the locking system and staff’s inability to quickly locate and operate keys in an emergency evacuation make the Waxter Center dangerous.

Our investigation also revealed that staff members overuse seclusion as a means of group management and punishment. We believe this misuse of seclusion results from the Center's chronic shortage of well-trained experienced staff and its lack of a strong behavioral management system that would provide an alternative to seclusion.

Specifics about each of these findings are detailed below.

1. The Waxter physical facility is inadequate for use as a secure detention facility.

The physical plant of the Waxter Children's Center is antiquated and poorly designed for the housing of youth. The architecture of the building is not adequate to meet the security needs of the population currently housed there.

a. Locking System Issues

The manual locking system is dangerously inadequate and poorly administered. Many of the locks are difficult to operate or do not work at all. They can easily be jammed. During our visits to the facility, staff members repeatedly experienced difficulty opening and closing locks, and in several instances were completely unable to open a faulty lock.

None of the staff interviewed was able to consistently identify keys and their designated locks. Both children and staff remarked upon the inability of staff to open doors when required to do so. When trying to open a door to an individual room, even the facility Superintendent remarked, "I just don't know what would happen if we had a fire…"

One example illustrates the potential danger. Moving from the front exterior of the facility to the day room on the "B" Unit requires unlocking six sets of doors. Most girls on the "B" unit sleep in individual detention cells, each of which is also manually locked. In an emergency evacuation of the building, staff would need to manually unlock each of the individual cells and six sets of doors to evacuate the "B" Unit. This task would be daunting enough even if all keys were color and touch coded, if staff were fully trained to identify keys by touch, and if all locks worked properly. Unfortunately, the opposite is true - staff repeatedly struggle with the locks, keys are not color and touch coded, and staff members demonstrate an inability to quickly identify keys. We believe this to be a serious safety hazard.

Applicable Standards

Maryland Department of Juvenile Services Standards for Juvenile Detention Facilities 6.2.3. "The internal design and appearance of a secure detention facility shall, to the extent possible, in considering the security needs of the program, *provide a safe,* humane, caring *environment***.**" (emphasis added)

Maryland Department of Juvenile Services Standards for Juvenile Detention Facilities 5.1.2.4. "Emergency keys shall be identifiable by touch."

American Correctional Association Standards for Juvenile Detention Facilities, Standard 3-JDF-3B-12. "Written policy, procedure and *practice (should) specify the means for the immediate release of juveniles from locked areas in case of emergency* and provide for a backup system." (emphasis added)

b. Facility Design Issues

The architectural design of the "B" unit is inadequate to provide a secure environment for youth and staff. The ceiling is so low in the dayroom that the youth can reach up and pull down ceiling tiles and lighting fixtures. Fire sprinklers attached to the ceiling are not tamper-proof and are within easy reach of youth. If the sprinklers are set off, a staff person must go outside the building to turn off the water and the fire department must be called. Because of the design of the building, which includes long hallways lined with rooms and heavy doors dividing the various areas, there are no clear sight lines. It is impossible for staff to maintain visual supervision of youth, especially in times of emergency.

Applicable Standards

Maryland Department of Juvenile Services Standards for Juvenile Detention Facilities, Standard 6.6, Environmental Conditions. "With consideration given to management concerns and the goal of normalization, the living arrangements shall conform as nearly as possible to those provided for non-secure facilities. *Items such as heating, ventilation, lighting and plumbing shall be provided consistent with the security needs of the facility* and shall conform to uniform building codes and state and local applicable codes for plumbing, mechanical and electrical systems." (emphasis added)

c. Individual Detention Cell Issues

The individual cells are not appropriate for youth as sleeping rooms, or as seclusion cells. Beds are not suicide proof. No toilet facilities are located in the rooms. Youth are locked in the rooms at night and must rely on staff to be released to use toilet facilities. There are no adequate facilities for the storage of personal items, nor are any allowed in the rooms.

Maryland Standard 6.5.2 (below) does not require that residents have access to in-room water or furniture or that residents be able to access toilet facilities without staff assistance. We believe, however, that this Standard "affords inadequate protection of the health, life, safety and humane treatment of youth," (Standard Operating Procedures for the Independent Juvenile Justice Monitor, Nov., 2003), and that it also conflicts with Maryland Standard 6.2.3 (see p. 5) requiring that facilities provide a *"safe, humane, and caring environment."*

American Correctional Association Standard 3-JDF-2C-03 (below) ensures a more appropriate residential environment for children, including the availability of in-room water and furniture and access to toilet facilities without staff assistance. We believe that these conditions are the minimum acceptable conditions to ensure that an environment is "*safe, humane, and caring."* (Maryland Standard 6.2.3)

Applicable Standards

Maryland Standards for Juvenile Detention Facilities, Standard 6.5.2, Resident Rooms. "Each resident shall be afforded: a clean, dry room of moderate temperature, equipped with light sufficient for reading during regular waking hours; and access to adequate toilet and bathing facilities."

American Correctional Association Standards for Juvenile Detention Facilities, Standard 3-JDF-2C-03. "Each sleeping room has at a minimum the following facilities and conditions: sanitation facilities, including access to toilet facilities that are available for use without staff assistance 24 hours a day; a wash basin with hot and cold running water; a bed, desk, hooks or closet space, chair or stool; natural light; temperatures that are appropriate to the summer and winter comfort zones."

2. Staff inappropriately uses seclusion as a group control mechanism.

According to the Waxter Center Seclusion Logs, youth were placed in seclusion 115 times during January and February, 2007. Many of these seclusions lasted 48 hours, and some youth remained in seclusion for as long as 3 days. It appears that seclusion has become the only viable control mechanism available to staff, and it is used whenever there is a loss of control.

Interviews with staff and children also make clear that seclusion is regularly used as punishment. A review of the seclusion logs corroborated their views. On at least five separate occasions during this two-month period, as many as 12 girls were placed in seclusion at one time, remaining there for extended periods of time ranging from 24 hours to three days.

Department of Juvenile Services Standards prohibit keeping a child in seclusion once she no longer presents a danger to herself, others, or property and can be managed with a less restrictive method of behavior control. An examination of the Seclusion Door Sheets during many of these instances of "group seclusion" revealed girls who were "sitting quietly on (the) bed," "reading," etc. No other documentation exists to explain how it was determined that these girls continued to pose a danger justifying such lengthy seclusion.

Applicable Standards

Maryland Department of Juvenile Services, Policy Number 03.14.04, IV, B - Use of Locked Door Seclusion: "A facility employee may place a youth in locked door seclusion only if…clearly necessary to prevent…imminent physical harm to the youth or other individuals; imminent and substantial destruction of property; or escape…"

Maryland Department of Juvenile Services, Policy Number 03.14.04, IV, B - Use of Locked Door Seclusion: "(A) facility employee may not place a youth in locked door seclusion as punishment…. A youth shall be released from locked door seclusion when the youth no longer fits the criteria for placement in locked door seclusion."

3. Misuse of seclusion is a result of chronic staff shortages, insufficient staff training, and staff inability to control population using other methods.

The Waxter Children's Center suffers from chronic staff shortages. On the evening of January 22, 2007, eight staff were on duty. According to the Superintendent, there should have been 10 staff and a shift commander in the building. When the sprinklers were set off and one staff had to leave to turn off the water, only one staff member was present on the "B" unit to supervise 20 girls who were out of control. Because the staff was overwhelmed, it was necessary to call the State Police to restore order.

On January 31, the Superintendent reported that she had 22 staff openings (10 vacancies and 12 staff out of commission) and on February 22, she had 10 openings. Staff reported that they are unable to participate in required training because there are insufficient staff members to cover shifts. The Superintendent indicated that she is often called upon to cover a shift.

In addition, the chronic shortage of experienced, trained staff has undoubtedly contributed to the lack of control of the youth in the facility and the improper over-use of seclusion.

Interviews with staff revealed that many have not been provided with appropriate training to administer the behavior modification, or "point" system. The failure of staff to properly administer the system of punishment and rewards (by informally giving candy to girls who were not eligible per the "point" system) contributed to the loss of control on January 22.

Children in the facility who were interviewed consistently reported that a culture of disrespect and verbal abuse exists. Girls reported being called "fat asses" and "witches" by staff members. Girls also reported being pushed and handled in a rough manner by staff members.

One such incident was observed by Deborah St. Jean of the Office of the Public Defender, on January 12, 2007, and reported in a letter to the DJS Assistant Secretary of Residential Services, James Smith. A Special Timely Report was issued by this office in September, 2006, documenting an assault on a child by staff.

It is our professional judgment that these unacceptable incidents of mistreatment of children are a direct result of overworked and under-trained staff.

Applicable Standards

Maryland Department of Juvenile Justice Standards for Juvenile Detention Facilities, Standard 5.1.3, Staffing. "Youth to staff ratios developed by the Department shall ensure supervision of youth. The allocation, deployment and assignment of resources/personnel to each facility shall be based on …the budgeted population operating capacity…the level of risk and needs of the population … facility programs and services; and…physical plant architecture. Staff to youth ratios shall not be

generalized, but rather based on facility design and age, activity and program level and other related factors."

RECOMMENDATIONS

1. The Waxter Center physical facility has outlived its usefulness as a housing unit for children. The deficiencies of the physical plant threaten the safety of children and staff. It would be virtually impossible to improve the physical plant sufficiently to make it suitable for a secure detention program. We believe the children who are housed at Waxter should be relocated to an appropriate facility at the earliest possible date.

2. A workable key system should be instituted immediately.
   a. All facility keys should be color and/or texture coded to be easily identifiable in an emergency.
   b. All locks should be opened easily with keys.
   c. All staff members should be tested until they can rapidly identify emergency egress keys by touch.

   If such a system cannot be instituted immediately, we recommend that all internal facility doors be unlocked at all times.

3. The Waxter Center Superintendent should request that the State Fire Marshal perform fire safety inspections and drills on at least a monthly basis.

4. A viable behavior modification system should be developed for the population. Staff should be well-trained in that system and in other acceptable alternative behavior control systems to reduce the over-reliance on seclusion as a control mechanism.

5. Until staff members are trained adequately, seclusion should be prohibited in this facility. If a child becomes out of control, that child should be transferred to an appropriate medical facility.

6. The rated population of the facility should be determined in part by the number of staff available to supervise them. As long as Waxter suffers from chronic staff shortages, the rated population should be reduced to meet acceptable staff/youth ratios. These ratios must take into consideration the challenges presented by the architecture of the physical plant. The Center should not accept new residents beyond its rated population limit.

7. The administration should consider bringing in trained mediators or other appropriate crisis management experts to address the ongoing and increasingly violent conflicts among the residents.