California
Department of Corrections and Rehabilitation

O.H. Close
Youth Correctional Facility

STAFF SAFETY EVALUATION

August 3 – 18, 2005

CORRECTIONS STANDARDS AUTHORITY
600 BERCUT DRIVE
SACRAMENTO, CALIFORNIA 95814

WWW.CSA.CA.GOV
916-445-5073

BACKGROUND

In March 2005, Secretary Roderick Hickman requested that the Corrections Standards Authority (CSA), develop a plan to evaluate staff safety issues at all of the state's adult and youth detention facilities. At the May 19, 2005 meeting of the CSA, the proposal was presented and accepted. On May 24-25, 2005, a panel of state and national subject matter experts was convened to establish the criteria by which the evaluations would be conducted. Based on those criteria, a team was developed and a timeline of evaluations was established.

On August 3-18, 2005, a team comprised of staff from the California Department of Corrections and Rehabilitation (CDCR) Corrections Standards Authority (CSA), Adult Operations and Juvenile Justice Division conducted a Staff Safety Evaluation at the facilities located in the Northern California Youth Correctional Center (NCYCC) complex. Four separate youth facilities are located within the NCYCC including the DeWitt Nelson Youth Correctional Facility (DWNYCF), the O.H. Close Youth Correctional Facility (OHCYCF), and the N.A. Chaderjian Youth Correctional Facility (NACYCF). The Karl Holton Youth Correctional Facility (KHYCF) is the fourth facility but it is not currently being utilized. Each of the three open facilities was reviewed individually and the results documented in separate reports.

The evaluation protocol consisted of a request for advance data on staff assaults from each facility including victim and perpetrator data, a site visit of the physical plant, random interviews with various custody and non-custody staff, a review of applicable written policies and procedures governing the operation of the institution and a review of documentation including incidents of staff assaults, staffing levels, ward population, staff training and safety equipment.

EVALUATION METHODOLOGY

An entrance letter was sent to the OHCYCF Assistant Superintendent, Heyman Matlock, informing him of the August 3-18, 2005 site visit dates and the proposed operational plan (Attachment A). The criteria panel had suggested using a data matrix to record information from the Serious Incident Reports (SIR) for staff assault or attempted assaults by wards to determine if any trends could be identified. The institution staff was asked to review the reports and complete the matrix before the site visit (see Attachment B). The evaluation team asked that all incident reports and related documentation be made available during the site visit. As the evaluation progressed, the team identified other information appropriate for review and staff at the institution provided copies of existing documents, or researched their records for information.

The Facilities Standards and Operations Division of the CSA led the evaluation team. The team was divided into three work teams, each comprised of staff from the CSA, Adult Operations and Juvenile Justice Division (each team had a member from each discipline – see Attachment E for a roster of team members and assignment).

The evaluation began on August 3, 2005, at the NCYCC, with a joint entrance conference that was attended by each facility's superintendent/assistant superintendent, appropriate institutional administrative staff and evaluation team members. The conference included an operational

overview of the institution by Assistant Superintendent Harada as well as an overview of the evaluation process by CSA Field Representative Bob Takeshta.

Using the Boardroom at OHCYCF as the base of operation, the team broke into workgroups and began the review process but continued to meet daily to discuss their observations. Available documentation was reviewed relative to the physical plant configuration, policies, safety equipment, staffing levels, staff assaults and ward population. The group looked for any trends or related issues.

The physical plant team reviewed the institution design as it related to staffing, current procedures and the ward population. The purpose was to identify any issues that would affect staff safety such as crowding, limited visibility, insufficient supervision or lack of communication.

Facility managers as well as staff and supervisors on each of the three watches were interviewed to provide an opportunity to identify their concerns regarding staff safety issues. A questionnaire was developed in preparation for the review to ensure some consistency among the interviews and is included as an attachment to this report (see Attachment D). The responses were categorized and a summary of the responses is included in the Staff Interview section of this report (pages 23-27). Conflicts between the documentation, the staffs' perception of the practice and staffs' concerns for safety issues were noted during the interviews and are included in this report. The review team also made their own observations and those are noted.

A joint exit conference was conducted on August 18, 2005 with Eric Umeda, Acting Superintendent NACYCF; Steve Gardner, Major NACYCF; Heyman Matlock, Assistant Superintendent, OHCYCF; Anthony Lucero, Treatment Team Supervisor OHCYCF; Jeff Harada, Assistant Superintendent, DWNYCF; Michael Minor, Chief of Security, DWNYCF; Bernard Warner, Chief Deputy Secretary of the Division of Juvenile Justice (DJJ); Yvette Marc-Aurele, Deputy Director of Institutions and Camps Division of the DJJ; Elizabeth Siggins, CDCR Juvenile Policy and Sharie Wise, CDCR. The exit conference included a presentation of the team's findings and observations as well as a summary of comments made by staff.

FACILITY PROFILE

O. H. Close Youth Correctional Facility (OHCYCF) is located within the Northern California Youth Correction Center complex (NCYCC), in Stockton, California. The Center includes three other youth correctional facilities, each being utilized to provide services to a selected ward population. The Youth Authority Training Center is located next door to and outside of the secure perimeter of the NCYCC.

OHCYCF was initially opened in 1967 as a young boys program to address the needs of truants and runaways under the age of 18. The housing units are named after the counties in California. OHCYCF uses a variety of resource groups and community programs to facilitate a ward's growth and development in preparation for his reintegration into society. OHCYCF wards from Humboldt Sex Offender Program, Fresno Substance Abuse Program and Glenn Young Boys Program provide public service participation by engaging in the presentation of services and programs at this institution. Such services include conducting tours to judges and other officials as well as performing work within the administration area.

Current Usage

The ward population at OHCYCF is generally limited to males under the age of 18 years. On the first day of our evaluation the facility housed 69 wards over the age of 18 years. With the closure of the Northern Youth Correctional Reception Center and Clinic (NYCRCC) in Sacramento in 2004, OHCYCF became the under 18 youth parole violator reception center for Northern California. The facility remains as an academic and vocational education institution to provide programs to as many as 251 wards attending classes each period.

This facility utilizes an "Open" program to achieve the Agency's overall mission of providing a "Normative Culture" program to wards. The intent is to promote responsibility and bring about behavior change among wards on regular program. The creation of this social environment includes the establishment of a community to promote positive peer influence.

While the living units at this facility are not segregated by gang affiliation or by race, careful attention is given to ensure no single group is allowed to be together in sufficient numbers to exert control over others.

The living units are individual buildings with dormitory configurations, separated by areas of grass and recreation courts. Each building has at least one wet room, which is not considered a sleeping room and is limited to short term use. Each living unit has the capability to video record daily activities. The facility has the capability to provide "close" security living or administrative segregation housing on the Inyo living unit. Crowding was not an issue at this facility.

OHCYCF offers three specialized programs including:

- The Fresno living unit Drug Program (RSAT) is a 6-month drug treatment program.

- The Inyo Detention Unit (Inyo living unit) is a 19 individual sleeping room Temporary Detention program (TD) designed to deal with "acting out" wards. Depending on behavior, a ward may be assigned to this program for up to 14 days by authority of facility management and for up to 28 days by authority from the Chief Deputy Secretary.

- The Humboldt living unit Sex Offender Program (SOP) deals with sex offenders and other wards with severe emotional problems.

Population Summary

The current design capacity at OHCYCF for all housing units is 400. Thirty-five rooms can be used as individual temporary detention rooms. On the first day of our evaluation, the facility housed 289 wards. The wards' ages ranged from 14 to 22 with an average age of 16.4 years. Sixty-nine wards (23% of the facility's population) were over the age of 18. Older wards may remain in OHCYDF because they could be near the end of their term or they may be participating in a particular program.

- Approximately 21 percent of the ward population has been committed for crimes involving sexual assault.
- Sixty wards are assigned to the Humboldt Sex Offender Program.
- Seventy-one percent of the population has been committed for crimes involving some type of assault.
- Fifty-two percent of the population has been identified as needing some type of drug counseling or drug intervention.
- Forty-seven wards are currently enrolled in the Fresno RSAT program.

While about 78 percent of the wards have histories that include documented gang affiliations, management staff informed us that many others are making efforts to become gang members. Those wards are impressionable, seeking recognition from their peers, trying to fit in and survive within the population. Staff went on to say that many of the wards remain defiant, argumentative and challenging to authority.

Fifty-five percent of ward population was Hispanic, twenty-two percent African American, thirteen percent Caucasian and ten percent were classified as "other".

Staffing Allocation and Availability

The management staff at OHCYCF consists of the Assistant Superintendent and a Captain designated the Chief of Security at the facility. On the initial day of our evaluation the funded staffing was established at 122 custody personnel (including the management staff), Lieutenants, Sergeants, Youth Correctional Counselors, Youth Correctional Officers, Parole Agent I/III, and Casework Specialists. OHCYCF has 7 custody personnel off work or otherwise unavailable for assignment. On the initial day of our evaluation the funded staffing allocation for non-custody personnel was 89 positions.

Medical services are provided at a central location for all facilities within the NCYCC complex. The Outpatient Housing Unit (OHU) is staffed with 33 medical personnel. Mental Health Services are also provided by a staff of six. Twelve MTAs are assigned to the OHU.

See Table I below for a summary of positions, vacancies, long-term leave and staff availability.

Table I

	Allocated Positions	Vacancies	Long-term Leave	Available Staff
Custody Staff	122	0	13	109
Non-Custody Staff	89	11		78
Total	211	11	13	187

PHYSICAL PLANT

This facility is comprised of nine living units contained within four buildings situated in a circular fashion around a large recreation field. Each building contains a dining hall. The medical clinic, control unit, chapel, educational classrooms and vocational spaces are also situated around the recreation field within the secure perimeter.

Educational services are provided onsite within the OHCYCF's secure perimeter. There are 25 classrooms. Some of these classrooms are vocational education programs. Some of the vocational programs available to the wards include landscaping, graphics arts, welding, and cabinet making.

Each of the living units has similar design configurations. An officer station is centrally located within each living unit. One long dormitory, a shower/restroom area and a dayroom are circularly located around the control room. Opening into the dormitory are twelve single-occupancy sleeping rooms. Two of these sleeping rooms are utilized as cool down rooms for wards requiring a brief period of room confinement. Each of the "cool down" rooms contain a combination wash basin/toilet unit and a camera that is monitored from the building's officer station. The remaining ten single-occupancy sleeping rooms do not contain plumbing fixtures. Additionally, office space and storage rooms are provided in each living unit.

Each unit has one staff assigned to the first watch, two staff on the second watch and three staff on the third watch. An additional staff is assigned to overlap the second and third watches.

The El Dorado unit contains a mixture of general population wards and wards assigned to a mental health program. Some of the wards participating in the mental health program are prescribed psychotropic medications.

The Amador and Butte units were closed and the time of the evaluation due to the low ward population. The Fresno unit houses wards assigned to a six-month drug treatment program. The Inyo unit contains 19 single occupancy sleeping room and houses ward placed on temporary detention

The evaluation team toured the institution, reviewed institutional procedures and interviewed staff at various classification levels. The evaluation team looked specifically at the overall conditions of the physical plant, the staffing levels within each area of the institution, and the number of wards within each building of the institution. The evaluation revealed the following concerns:

Physical Plant/Maintenance

Finding: The lack of maintenance for the entire complex contributes to an unsafe environment.

Discussion: The lack of maintenance is apparent immediately upon entering the front gate of the complex. Overflowing trash cans, lawn areas that were brown, flowerbeds overgrown with weeds, and fields of heavy plant growth were observed driving through the complex to the

facility. These same issues were observed within the facility. The following facility maintenance issues were observed throughout this facility:

ELECTRICAL

- Numerous perimeter fence lights are burned out/not working.
- Numerous interior lights are burned out/not working.
- The electrical supply is not sufficient for the demands of current equipment. This was particularly evident in the school area where only half of the computers and copiers could be turned on at one time without tripping the breaker.

PLUMBING

- Standing water was observed on the floors due to leaking pipes.
- Standing water and large puddles of mud were observed throughout the facility grounds created by leaking irrigation water lines.
- Team members observed many washbasins and showers that cannot be turned off and continually run.
- Exterior hose bibs continuously leak and create standing puddles.
- Numerous showers, toilets, and washbasins within each living unit were observed out of order.
- Each living unit has broken or missing urinals. Plant Operations reports these fixtures are antiquated and that replacement parts are no longer available. Furthermore, the standardized plumbing application utilized by modern urinals will not match up to the antiquated drain/water supply provided. As a result, modern urinals cannot be used as a replacement.

STRUCTURAL

- Window and doorframes are severely rusted in the shower/bathroom area. In some cases, the frames are no longer able to hold the glass and allow for pieces of metal to be pried away and used as a weapon.
- There is significant structural damage to walls in the shower areas due to leaky or broken water pipes and fixtures.
- In addition to peeling paint, large holes were observed in the interior walls on several units providing a haven for contraband and weapons.

VERMIN/VECTOR CONTROL

- Several evaluation team members observed ants and roaches and rodent droppings in the food preparation areas of the facility kitchen and in the central food service kitchen.
- Large populations of ground squirrels inhabit the complex and facility. The burrows create a significant safety issue for staff responding to emergencies and to the wards utilizing the outdoor recreation areas. Plant Operations personnel report the three large water storage tanks that supply water to the entire complex are in jeopardy due to the squirrels burrowing underneath them.

- Large populations of skunks inhabit the complex and facility. Evaluation team members observed skunks on the grounds. Supervisory staff reported occasions where staff were recently sprayed by skunks and sent home.

HVAC

- The living units utilize swamp coolers. Staff reports that these coolers provide minimal cooling during the summer months and that temperatures within the living units typically exceed eighty-five degrees.

FENCING

- The sliding gate at the entrance to the complex is damaged and will not close. This gate is part of the primary security fence that surrounds the complex and helps prevent escapes and unauthorized entries.
- The bottom edge of the perimeter fence is not set in concrete. As a result, there are several areas where animals have burrowed under and created spaces for unauthorized entrance or egress.

CENTRAL KITCHEN

- Walk-in refrigerators, freezers and chillers have deteriorated to the point that some units cannot keep up and over heat. In some instances this is due to large holes that allow outside air to exchange with the cool air. In an effort to cool one of these refrigeration units, a garden hose with a sprinkler head continuously applies water to the unit. The water flows onto the unit and across a walkway, which is used daily by office staff. Algae have formed on the sidewalk forming a slip hazard. Standing water provides a breeding area for mosquitoes and mud is a constant problem as well.

EMERGENCY POWER

- Central plant operations for the complex utilizes LP gas to fuel the central boiler that supplies steam, hot water, and heat to central operations buildings within the complex. Additionally, LP gas is the fuel source for the emergency power generators that operate the domestic water supply delivery pumps and effluent pumps for the complex. In the event that the supply of LP gas were lost, a large propane tank is located on site that serves as a back up fuel supply. A conversion station is utilized to convert the propane gas into a compatible fuel for the generators. Plant Operation staff report this conversion station is in disrepair and the manufacturer will not supply parts for the conversion station due to its age and disrepair.

Providing proper levels of building maintenance is as important to the overall safe operation of a secure detention facility as is providing sufficient staffing levels. A seemingly harmless loose or broken bolt can become a potentially harmful weapon. The affects from many years of neglect endured by this facility were observed in every building trade. In many instances, it is obvious

that the solution to some maintenance issues has elevated from a simple repair to costly replacement.

Plant Operations staff reports that the maintenance staffing level was not increased in 1991 when the N.A. Chaderjian facility opened. Currently, there are 44.5 maintenance personnel assigned to the complex and only 28 of those positions are filled. Preventive maintenance does not occur at this facility or at any of the facilities within the complex. Maintenance occurs only on an emergency basis and the emergencies are prioritized daily. Due to the constant crisis mode, Plant Operations was unable to provide documentation regarding the number of work orders finished.

Finding: The work order tracking system currently utilized by Plant Operations and the facility is ineffective.

Discussion: Evaluation team members were unable to determine which work orders were addressed and which ones were still outstanding. Evaluation team members observed frustration with the tracking system by both Plant Operation staff and facility staff. The ineffective tracking system combined with a lack of communication between Plant Operation staff and facility staff combines to exacerbate the frustration level. The evaluation team recommends regular meetings between Plant Operations staff and facility staff to discuss and prioritize maintenance issues. Additionally, reexamination of the current work order tracking system is needed to ensure requests for work are addressed to the satisfaction of Plant Operations and facility staff.

Finding: There was heavy plant growth between the perimeter fences that could conceal contraband or aid in escapes. In some areas, the heavy plant growth is a fire hazard.

Discussion: While this is not necessarily a staff safety issue, the team recommends assigning regular landscape maintenance personnel to keep plant growth to a minimum.

<u>Staffing</u>

Finding: When teaching staff does not report for work for various reasons, a substitute is not brought in. As a result, wards are returned to their living unit to wait until the next period to return to the school program.

Discussion: Staffing within the living unit is reduced during the second watch (typically two staff as opposed to three staff on third watch) because the wards are scheduled to be out of the living units and in school during this time. The evaluation team observed groups of wards, numbering as many as twenty, within the dayrooms of several living units not attending school during school hours. Supervising these wards creates a safety issue for the living unit staff during this time. The team recommends either increasing the staffing in each living unit to adequately supervise and provide programming to the wards during the second watch, or provide sufficient numbers of teaching staff to accommodate the ward population.

Finding: The use of staff in vehicles monitoring ward escort/movement and some "patrol" functions is ineffective.

Discussion: Security staff (YCO) is assigned to the large movement yard and are responsible for monitoring the movement of ward to and from various activities. This is accomplished with vehicles being used to follow wards from housing units to school activities and other movements. Additionally, security staff responding to incidents within the facility also uses the vehicles.

Consideration should be given to eliminating the use of staff patrol units to escort wards during ward movements. Staff presence in a vehicle during ward movement ensures the wards report to the proper areas, but it does not provide interaction or direct supervision of the movement. Staff assigned to the vehicle cannot hear the conversations of the wards. Staff posted in vehicles are ineffective in quelling disturbances. The elimination of the vehicle escorts and posting of staff on foot as escorts would greatly enhance the escort process. This would allow the staff to communicate with the population, gather intelligence, and identify the victims and assailants should an incident occur during ward movement.

Additionally, security staff assigned to the large movement yard should be assigned specific duties to patrol and monitor the units during movement and non-movement periods. These staff could tour the living units, provide individual escorts, random searches of common areas, ward cells/rooms and wards themselves. Each position could be responsible for specific housing units and should remain visible at all times. With specific responsibility for assigned units, security staff could be in a better position to respond to emergencies, or assist unit staff should the need arise.

Finding: Direct supervision of security staff is not being adequately accomplished.

Discussion: Currently there is not an assigned security and escort supervisor or recreation field area supervisor dedicated to the sole supervision of security staff assigned to the housing units or to the facility's large recreation yard. Instead, YCOs assigned to these areas are supervised by security supervisory staff who are assigned other duties and posts that require their constant presence. The evaluation team recommends assigning a facility Sergeant on both 2nd and 3rd watches dedicated to supervise the work of the YCOs assigned to the units and to security and escort functions.

Finding: Current staffing patterns do not allow for the Senior Youth Correctional Counselors (SYCC) to adequately supervise the YCCs assigned to each hall housing wards.

Discussion: There are frequently times when there is not an SYCC assigned to a unit to oversee the staff working in the unit. Also, when SYCCs are present, they are assigned to a posted position and cannot leave their assigned hall to provide supervisory oversight in the sister hall of the unit. The evaluation team recommends assigning a SYCC (that does not have post assignment responsibilities) to each unit on the 2nd and 3rd watches. This would allow for more effective supervision of YCCs and of the program delivery.

Finding: At times, there are too few security and escort staff to safely respond to emergencies within the facility.

Discussion: There are only two security and escort staff assigned to each watch. At times, multiple alarms occur simultaneously within the facility. An additional security and escort staff should be assigned to each watch.

Procedures

Finding: The DJJ lacks a formal objective classification system. The current method for determining ward facility and housing assignments fails to account for the security and custody needs of the youth.

Discussion: When asked how the institution managed the ward population, we were told that the agency had no central classification system. An in depth and detailed assessment of each ward is performed at intake into the system but the information is not readily available to staff members dealing with the ward in the living units. Currently the DJJ Headquarters decides placement based on age and program needs. At the facility level, staff uses several factors to decide placement. Age, program needs and gang affiliation appear to drive the process of housing wards. The Parole Agent III constantly monitors the distribution of known gang members among the lodges to maintain a balance so that no one group is of sufficient numbers to dominate over others. The role requires constant intelligence gathering as well as frequent monitoring of current placements.

Program designation for the more difficult to manage wards is also determined at Juvenile Justice Headquarters and in consultation with mental health services providers. Adjustments are made depending on the ward's progression in the assigned program.

Another classification related measure is the category level of the ward. Categories 1-7 are determined at the time of intake into the state system. The levels are based primarily on the original crime for which the ward is committed. Categories 1-2 are the highest security level and include wards committing murder and serious assaults. Categories 5-7 are the lowest and typically include wards failing to complete programs at the local level and the sentencing judge referred them to the state. This measure is seldom used to determine placement because it is not a dependable indicator of the ward's conduct while in custody.

Local adult and juvenile detention facilities and the Adult Operations Division of CDCR utilize a means of identifying those in their care who require different security levels and/or housing needs to ensure the safety and security of the person in custody, others in custody and the staff. A formal classification system is planned for the youth correctional system but it is not operational. The system is expected to include: an intake risk needs assessment, a custody/security classification and reclassification process, and a parole risk/need assessment. Staff was unaware of an expected start date for implementation.

The team recommends that the Juvenile Justice Division continue to develop a system for identifying and reviewing the security needs of each ward in custody and identify specific housing and programming based on those needs. It is further recommended that policies and

procedures be developed for each type of housing unit based on the classification of wards being held.

Finding: Staff reported that emergency fire evacuation drills are not be conducted.

Discussion: The First watch staff have indicated they do not conduct any simulated Fire Drills. The second and third watch staff indicated that the emergency fire evacuation drills are not consistently conducted. Specifically staff reported that to the best of their memory these drills have not been conducted within the last two years. Additionally we could not locate any documentation within the living units or control center to support evacuation drills have been conducted. Emergency fire evacuation drills are necessary to ensure the safety of the staff working at this facility as well as the wards in their care.

Finding: There is no accountability for tools maintained in the units.

Discussion: Staff reported that barber boxes and unit tools such as scissors, barber tools, brooms and mops are not being inventoried. Methods are needed to accurately inventory tools and equipment to which wards have access.

Finding: Post orders for the YCC and YCOs do not contain the signature of authority or date of revision. There is no process in place (in the units) to ensure staff has read and understand the requirements of the post orders (post order acknowledgement).

Discussion: Updated post orders are essential for the safe operation of detention facilities. The high turnover of staff working on units they are not normally assigned to or familiar with exacerbates this situation.

Finding: Post orders provided by staff posted within each living unit were outdated and may not reflect current practice.

Discussion: Of particular concern were post order related to emergency response duties for the staff posted within the living unit. The team recommends updating post orders and providing training to staff regarding emergency response duties.

Finding: Staff indicated that individuals are assigned to the emergency response teams as they report to work. The unit post orders did not delineate responsibility for emergency response. In addition unit staff were uncertain as to who would respond to incidents or emergency situations and what security equipment to take.

Discussion: Updated post orders and procedures requiring staff to read and understand post orders are essential for the safe operation of detention facilities.

Finding: No documentation was present to support that area searches are being conducted.

Discussion: Documentation was not present requiring the searching of school classrooms, maintenance areas, common grounds, vocational education areas etc. Although staff reported

some searches were being conducted, there was no documentation indicating that a search had taken place. Procedures for ongoing random area searches and documentation of those searches are essential components of maintaining a safe institution.

Finding: Staff were unable to produce current policy and procedures regarding emergency procedures, deployment of chemical agents, or daily operations procedures.

Discussion: Staff relied on memos issued by the facility management for direction on many of these policy matters and developed their own procedures for implementation. Secure detention facilities must have clear policy and procedures that direct the daily operations of the institution.

REVIEW OF DOCUMENTATION

Team members reviewed available documentation, including reports, records and policy manuals to identify any trends or common themes among incidents. The team also noticed some general areas of concern and included them in the discussion. The items reviewed included:

- Serious Incident Reports for staff assault or attempted assaults (SIR) for 12-month period (2004/2005).
- Staff Assault Review Committee Minutes.
- State Compensation Reports (SCIF) for assaults on staff.
- Safety Committee Meeting minutes including the Risk Management Plan.
- Inventories of authorized safety equipment.
- Use of Force Executive Review Committee findings.
- Facility training records.
- Corrective action plans from previous audits and inspections.
- Employee safety grievances.
- Daily Operations Reports.
- Duty Roster Worksheet for first day of site visit.
- Involuntary overtime by inverse seniority records.
- Staffing information.
- Classification records.
- Ward files as requested.
- Ward Grievances.
- Youth Authority Manual (YAM).
- Institutions and Camp Manual.
- Institution Operation Manual.
- Administrative Summary.
- OBITS Report.
- Summary of the annual Safety and Security review (1800 Report).
- Section 4000 Audit Report.
- Section 7000 Audit Report.

Staff Assault Incident Reports

Finding: Insufficient data was available to identify obvious trends relative to the issue of staff assaults.

Discussion: After a collective review and discussion of the above listed documents, there were a few notable statistics; however, no issues were identified as being significantly consistent among the various incidents. Ten incidents of battery on staff were reported during the 2004-2005 fiscal year at the O. H. Close Youth Correctional Facility. After review, the team saw no significant trends.

- The victims were limited to those job classifications of Senior Youth Correctional Counselor, Youth Correctional Counselors, Youth Correctional Officers, Parole Agent and a teacher. No medical staff were involved.
- The victims included 5 males and 5 females.
- The race of the victims included:
  - 6 white.
  - 4 black.
- The average age of the victims was 38 with 5 of the victims being over the age of 45.
- Six of the victims had over 10 years of experience with the department and the remaining four victims had four or less years of experience. All had over 2 years of experience.

Finding: Race, age, gang affiliation and length of time in custody shed little light on the profile of assaultive wards.

Discussion: No significant variance was noted when comparing the race, age or length of time in custody of the assaultive wards to that of the overall ward population. African American wards were involved in three incidents, Caucasian wards where involved in three incidents, Hispanic wards were involved in two incidents, a Native American ward was involved in one incident and an Asian ward was involved in one incident, a ratio not inconsistent with the facility population.

The average age of wards involved was 16, just below the facility population's average age. All of the wards involved in the incidents have documented gang affiliations. No single gang was dominant among the combatants. Eight of the wards had been at OHCYCF more than 13 months; one ward had been at OHCYCF for four months.

Finding: Hours of the day may be factors in assaults on staff.

Discussion: The frequency of incidents was highest during the third watch with 6 occurrences, 3 occurrences on second watch and one occurred during first watch. Three incidents occurred within a 9-day period in May 2005. These three incidents appear to be unrelated. The remaining incidents varied in months separating them. No incidents occurred on Friday or Saturday. The majority of incidents took place on Mondays.

Finding: Insufficient data existed to identify any relationship between the wards involved in assaultive behavior and their program involvement or housing assignment.

Discussion: Seven incidents involved wards on general program status and three incidents involved wards participating in a special program. Two were in temporary detention (TD) and one was in a sex offender program (SOP).

Two incidents of staff assault occurred in each of the following locations: Glenn Hall, Del Norte Hall and the school area during the years of 2004/2005. One staff assault occurred in each of the Inyo, Humboldt and Calaveras Halls. OHCYCF assault information suggests that most assault were by the wards hands and objects thrown at staff.

Finding: Ward manufactured weapons were not factors in assaults on staff.

Discussion: Ward-manufactured weapons were not utilized in the incidents reviewed. Two of the assaults involved gassing. In three of the incidents, a book, ball, or shoe was used and thrown at the staff person. In four of the cases reviewed, wards used their hands to batter or attempt to batter staff. One case involved a ward using his foot as the weapon.

Finding: Statistics provided by the safety officer support the need for increased training in areas including ward relations, and officer safety. Reinforcement by supervision at all levels is needed to ensure the information received during the training is applied in the workplace. Further, injuries do not appear to be initially well documented.

Discussion: In the Serious Incident Reports reviewed from fiscal year 2004-2005, the victims initially reported no serious injuries and few required immediate medical attention following the initial treatment at the institution's infirmary. A review of the safety records suggests the injuries are much worse. The safety officer reported that five victims were off duty as a result of assaults. One victim has been off duty for almost one year.

Finding: The safety officer has made significant efforts to promote safety among the staff.

Discussion: The safety officer holds regular safety meetings and includes the appropriate persons. Recent injuries are discussed. Action plans are developed and reviewed at subsequent meetings. The safety officer at DWNYCF writes a monthly safety newsletter and shares with other safety officers at the NCYCC complex. The safety officer at OHCYCF sends relevant safety information to all staff via electronic mail monthly. The newsletter produced by DWNYCF is posted for staff to review.

Finding: Current staffing levels have resulted in mandated overtime for custody staff.

Discussion: Custody staff members are ordered to work overtime at an average rate of 12 times per month. Managers explained that the need for overtime backfill stemmed from heightened sick leave usage following a change in the employment contract. The absent officer must be backfilled as well as officers off work for training, vacation, or absent as a result of a vacancy. The issue is a concern for the increased potential for staff injuries, increased worker compensation claims, increased sick leave usage and effects on employee morale.

Finding: Staffing levels among non-custody staff may be an underlying cause for concern for staff safety.

Discussion: OHCYCF has 11 vacancies among the allotted 89 non-custody positions. Of particular concern, 10 of the 40 educational staff positions are vacant. The team was told that due to budget constraints, teachers are not replaced when they are absent from work and the class is cancelled. When wards are not in the classroom, they are returned to the living unit where custody staff is at a minimum.

Finding: The Institutional Policy Manual needs to be reviewed and updated.

Discussion: The review page used to document revisions and updates in the front of the manual reviewed by the team had not been completed. No revision dates or signatures of authority were entered. Pages within the policy manual were dated 1999. Absent these indicators, it is difficult for staff to determine if these procedures are outdated, current, or reflect procedural changes to the emergency operational plans.

Finding: The Institutional Policy Manual sections pertaining to emergency response and staff accounting need to be reviewed and updated.

Discussion: The review page contained within the Institutions Multi-Hazard Emergency Plan was dated February 17, 2005; however, it did not contain signatures of authority on the specific procedures. Absent these indicators, it is difficult for staff to determine if these procedures are outdated, current, or reflect procedural changes to the emergency operational plans.

The review team noted that the institution's Policy and Procedures Manual, and the Youth Authority Manual (YAM), do not include a written emergency plan for the visual accountability of on-duty staff. The institution currently utilizes the Identix/Bio-Metric System to process employees in and out of the institution. However, this system has not functioned properly in the past 14 months. While the entrance building has a check–in/out process for staff and visitors; there is no written documentation that details how staff are accounted for in the event of an emergency.

A review of the Facilities Multi-Hazard Emergency Plan for Mutual Aid response revealed that the current procedure (OHC Resource Supplement 28) is very vague, outdated and contains incorrect information. Some contact phone numbers are wrong and one contact agency, the Northern California Women's Facility (NCWF) no longer has available resources. Mutual Aid agreements are in place, however they are vague and outdated.

Training

Finding: Custody staff appear to be receiving training in safety related issues, but mandated annual training hours are not being completed.

Discussion: The policy manual sections reviewed by the team specify that custody staff receive a minimum of 52 hours of annual training. The policies identified a baseline of training topics to be included. Institutional-specific training supplements the baseline in order to total the 52 hours of required training.

The Training Manager provided documentation concerning the delivery of mandated training for custody staff. The documentation reviewed was not in compliance with policy. Custody staff was provided less than the required hours of annual training during the last 13 months (July 2004 through July 2005). Selected non-custody staff was also included in the training offerings; if it was determined the training was related to their duties.

The annual training included the following subjects:

- Water safety, 2 hours

- Staff/Offender interaction, make-up, 4 hours
- Team meetings/safety/security, make-up, 4 hours
- First aid, 4 hours
- CPR, 4 hours
- Staff/Offender interaction, 1 hour
- Injury Illness Prevention Program (IIPP), 2 hours
- Respirator fit testing, 2 hours
- Use of force, 2 hours
- Other mandatory and miscellaneous subjects including: Code of Silence, suicide prevention, drugs and medication, staff/supervisor interaction and disciplinary decision making system.

Finding: Tracking attendance and ensuring all persons actually attend training as scheduled remains a challenge for the Training Manager. The team members were concerned that not all officers were trained on the appropriate subjects. A dedicated training manager may ensure all staff receive the appropriate training.

Discussion: The attendance rate at training appeared to be about 94% among the officers scheduled to attend. Training records only track hours, not which classes were actually attended. Limited follow up is done to ensure absentees attend the "make-up" classes. The training manager indicated that he was unable to fully track absentees due to the lack of clerical support. The training manager told us he has several duties other than training and training is not his primary assignment. If staff missed training assignments the training manager has attempted to forward information to managers to address their employees. The training manager reported that staff might be disciplined if they do not attend training. Not all officers were sent to all of the training classes. The Training Manager said headquarters determines which training classes are relevant to certain assignments and designates specific staff to attend. . With few exceptions, because of mandated overtime, all officers have the potential of working all possible assignments and should receive the appropriate training. The training manager indicated that most training is conducted on an overtime basis due to the abolishment of 7K.

Finding: Policies for orientation and training of non-custody staff have not been updated since 1999. Many non-custody staff receive little or no initial training or new employee orientation.

Discussion: The policies specified that all non-custody staff receive 16 hours of orientation training prior to assuming their regular duties and that they receive annual update training as designated by the Superintendent. The Training Manager is not always informed of the arrival or departure of employees. He said, when he is informed of the hiring of a new employee, the Captain provides a one-hour tour of the facility and one hour of orientation and uses a checklist to document the orientation, far short of the 16-hour training requirement.

Finding: No special training is provided to staff members specific to officer safety in combative/assaultive situations.

Discussion: A 2-hour update regarding use of force is limited to the policy intent. Actual application techniques are not included. A review of the training documentation revealed no

annual update classes regarding control holds, restraint application, defensive tactics, weapon take-aways, weaponless defense, and chemical agents.

Finding: No special training is provided to staff members who act as training officers for purposes of orientation training.

Discussion: Supervisors and managers interviewed said the orientation training officers are selected based on the manager's personal assessment of the staff selected to provide the orientation. No formal process is used to recruit and select trainers. No special training is provided to staff members who act as training officers for purposes of orientation training.

Finding: No formal training program is in place to provide "field training" to newly appointed officers.

Discussion: The team asked if a "field training" program was in place to train new recruits (custody staff). Supervisors and managers interviewed said the orientation provided to new employees is limited to a 16-hour orientation process. No specialized training officers are utilized for the training/orientation.

All deputy sheriffs, police officers and the majority of local juvenile and adult correctional officers are required to complete a formal training program under the direction of a specially trained patrol officer. The program is designed to ensure the trainee is exposed to most situations that would be routinely encountered during the assignment and instructed on the expected performance. The field training program ensures the employee performs within the applicable law, the department's policy and in a safe manner. The training officer observes the employee's performance at regular intervals, documents the progress and provides any necessary remedial instruction. The trainee must demonstrate competence before being allowed to function alone in the position. The team suggests the DJJ consider developing a formalized institutional training program for new recruits and an abbreviated program for newly transferred officers.

Finding: The Supervisors are not receiving annual refresher training necessary for their positions including effective supervision, leadership, discipline and contract agreements.

Discussion: After discussions with staff and upon review of the training records, it appears that any supplemental training or update training regarding supervision issues is dependent on the interest level of the facility management. No formal training plan was provided to the facilities to provide direction regarding supplemental supervision training. Instead, it is up to the facility management to decide appropriate and necessary training.

Finding: Training records do not reflect that Youth Correctional Counselors are receiving training updates specific to ward counseling and supervision.

Discussion: In the training records reviewed, the team was unable to identify annual training specific to the subject of ward counseling. The Institutional and Camps policy manual specifies that all YCC and YCO staff are to receive 16 hours of annual training.

Finding: An annual training plan needs to be developed for the facility in concert with an agency-wide annual training plan.

Discussion: When asked if an annual training plan was available to review, the team was told that the formal plan was available. All training directives originate from headquarters. Subject matter, lesson plans and the names of the designated attendees are included in the directives.

Training is often litigation driven or reactionary to a change in policy, practice or the law. Such frequent changes make long-term planning difficult. The Training Manager was aware and had a copy of the Agency's annual training plan. He understood it was still in the development stage and not been operationalized.

Finding: Training deficiencies at OHCYCF could be improved through better coordination and forming partnerships with other facilities within the NCYCC complex (e.g. YATC, NACYCF, DWNYCF and the Galt training center).

Discussion: The Illness and Injury Prevention Program (SB 198 mandate) training is not included in the annual training plan. The Illness and Injury Prevention Program (IIPP) training is coordinated through the Safety Officer at the facility and not the Training Manager. While the time and attendance of the IIPP training is documented and reported to a central training coordinator, it is not credited toward the mandated annual update. The team thought, depending on the subject matter, IIPP training might serve to satisfy both requirements if the programs were coordinated.

The Training Manager and the team suggested combining training resources with other facilities within the NCYCC complex and the Galt Training Center, to provide some of the training. The Galt Training Center is able to offer a 40-hour orientation class to all employees before they assume their duties. Training materials would be delivered in a consistent manner to all staff. Duplication of materials and resources would be reduced resulting in significant savings to the department.

The court liaison officer identified a training need in criminal case preparation including interview techniques, evidence collection and preservation, and other issues related to the successful prosecution of offenses committed within the facility. Information sharing with neighboring facilities and improved relations with law enforcement agencies might present opportunities to provide additional training to staff to improve investigative techniques.

Safety Equipment

Finding: The personal alarm system utilized by the facility is comprised of several systems. Each system is zone specific and staff must know what zone they are in and have the proper alarm actuator for the system to work.

Discussion: Most staff prefer to wear alarms as opposed to carrying a radio. Each living unit is assigned three radios for usage throughout the shifts. Security personnel are issued a radio use throughout the shift. The alarms are smaller than the radios and the history of wearing an alarm

precedes the radio. Two types of alarms are used because not all of the alarms will function properly in all areas of the facility. The building construction and signal coverage determine which alarm format provides the best service. Officers are issued the alarm most appropriate for the work location; however, staff report that even with the proper alarm equipment, there are areas within the facility that are not covered by the alarm systems.

Finding: The personal alarm systems used by staff are undependable.

Discussion: Staff reported there are several dead spots throughout the living units that do not receive the signal when activated. Evaluation team members observed several alarm tests where staff demonstrated these blind spots. The FM alarms do not provide coverage within the classrooms and a separate Unisec alarm system is utilized. Teaching and facility staff reports this alarm system is unreliable as well. If an article of clothing is covering a portion of the device, the signal will be blocked when activated. Additionally, there are dead spots throughout the school portion of the facility. Facility and teaching staff that were aware of the shortcomings of these alarm systems stated they felt reasonably comfortable with the personal alarm system, however, those that are unaware of these shortcomings are placed in an unsafe situation. Management staff reports that a new personal alarm system is in the installation process, however, this process is in its second year and no completion date has been provided.

Finding: Officers are provided safety equipment as specified by policy, but the inventory of specific items may be insufficient due to the facility size and design.

Discussion: Each officer is issued handcuffs, OC/Mace spray and latex gloves. Respirators are available in all living units and located in security vehicles. A "911 Rescue Tool", a tool used to cut a suicide ligature, is available in all living units and is issued to staff in roving assignments. CPR masks are available in the housing units and security vehicles.

The facility is large and many of the buildings that are occupied by wards are not living units, consequently, some consideration should be given to issuing safety items to officers rather than just making equipment available in the living units. A rescue could be delayed because a CPR mask or 911 Tool needed for an emergency occurring in a location other than a living unit was not readily available.

Finding: Stab vests have been issued to the Inyo living unit.

Discussion: Only the officers assigned to Inyo living unit are issued soft body armor stab resistant vests and a supply of vests is stored in the living unit for visitors or shift replacement staff to wear. The vests are not fitted to individual officers and must be relinquished when the officer changes assignment. The team agrees that the department should purchase addition vests to compliment the 8 vests on facility grounds.

Finding: Some stab vests need to be replaced and a formal replacement program needs to be in place.

Discussion: A review of the inventory revealed 8 vests labeled with manufacturing dates of March of 1996 and February of 1997; making them over 8 years old. Perspiration and cleaning materials can weaken the materials and reduce the effectiveness of the protective vests. The team agrees that OHCYCF is in immediate need of replacing the existing vest inventory.

Finding: Staff reports there are not enough personal radios for all staff and that the batteries in the personal radios assigned to them do not hold a charge. Furthermore, the staff does not have the capability of charging the batteries on the unit and must request another battery from central control. Staff reported that at times, four to five battery changes are needed per shift.

Discussion: Personal radios are the means by which staff communicates with each other. Sufficient numbers of radios with dependable battery supplies are necessary for the safe operation of the facility.

Finding: The O.H. Close sub-armory lacks adequate oversight and documentation.

Discussion: The evaluation team conducted an inspection of the O.H. Close sub-armory during the safety review. The sub-armory is located inside of the security perimeter adjacent to the vehicle and pedestrian sally port across from the administration building; however it is not visually monitored by staff 24/7.

The armory maintains a limited supply of emergency equipment, munitions and 37 mm launchers. The space appeared adequate for the storage of the equipment and munitions on hand. The expiration dates on the CN chemical agents were current, however nearing the 3-year shelf life. The Oleoresin Capsicum (OC) items were within a safe range of the 4-year shelf life.

The inventory of chemical agents, munitions, weapons and emergency equipment was not current and was dated April 2001. The sub-armory entrance log was more current; however, was not used since 7-19-05. Other related state approved armory forms were not being used.

A staff member should be assigned responsibility for the duties associated with the armory. Additionally, post orders are needed that clearly define processes for the inventory, maintenance and inspection of armory related equipment.

Finding: Staff is assigned Oleoresin Capsicum (OC) spray canisters. These canisters are not checked regularly and there is no procedure in place to ensure the canisters are operable.

Discussion: Staff report that they check OC canisters with the armory sergeant when the think the canister is near empty. Procedures are needed to ensure the Oleoresin Capsicum (OC) spray canisters are regularly checked to ensure they are operable. All staff should be issued an OC holder that is specifically designed to hold the canister in a safe and ready manner.

STAFF INTERVIEWS

Interview Process

The Staff Safety Evaluation Team conducted random interviews with custody staff, Sex Offender Program staff, and non-custody staff at the O.H. Close Youth Correctional Facility (OHCYCF) from Wednesday, August 3 through Friday, August 5. Members of the team interviewed staff about safety related issues (e.g., safety equipment issued to staff and their perception of personal safety at the institution). The list of specific questions asked by the interview team is included as Attachment D.

The Staff Safety Evaluation Team conducted random interviews with OHCYCF staff, on the first, second, and third watches at the following halls: Inyo, Fresno, Glenn, Del Norte, Calaveras, Humboldt, El Dorado, (Butte and Amador were closed for intake). Interviews were also conducted at the gymnasium and education classrooms. Custody staff classifications interviewed included: the captain, lieutenants, sergeants, correctional officers, and medical technician assistant. The Sex Offender Program included: parole agent III, parole agent I, senior psychologists, psychologists, treatment team supervisors, senior case management specialists, case management specialists, senior youth correctional counselors, and youth correctional counselors. Non-custody staff interviewed included: the medical physician, psychiatrists, registered nurses, principal, teachers, cooks, and office technicians.

Additionally, the evaluation team conducted random interviews with Central Services staff on second watch at the following areas, plant operations warehouse, laundry, kitchen, warehouse, plant operations manager, fire station, outpatient housing unit, chief medical officer, central services major, and central administration.

For purposes of this report, the interview team is summarizing staff safety perceptions that were shared by staff during our interviews. Responses are grouped for custody staff, the Specialized/Sex Offender Programs, and non-custody staff.

Custody Staff - Interview with Manager

The interview team met with the management staff on August 3, and asked them to describe their concerns for staff safety at OHCYCF. Members present at the interview were, assistant superintendent, captain, program administrator, both treatment team supervisors, parole agent III, supervising casework specialist, health and safety officer, supervisor of correctional education programs (principal), personnel supervisor, and senior psychologist. All of the management team concurred that the ward population has dramatically changed at OHCYCF. All agreed that more than 90% of the wards claim gang affiliation. Additionally, these wards demonstrate violent behavior towards other wards, which directly affects the safety of staff. Wards do not concern themselves about consequences for violating the institutional rules. With the possible closing of Inyo, (temporary detention halls with single cells which segregate assaultive and disruptive wards from the main population) all managers expressed concern that this would directly affect the safety of staff and the program/treatment of the ward population at OHCYCF.

Finding: It is critical that OHCYCF be allowed to maintain adequate programming space for assaultive wards, specifically Inyo Hall.

Discussion: When the team asked them about solutions to reduce staff assaults, they all agreed that the ward's behavior should dictate the program needs. They said progressive discipline is an important tool, and if wards constantly step outside the program boundaries, they should be held accountable for their actions.

The managers informed the team that wards could be placed on Temporary Detention Program (TD) at Inyo if they meet one of the following criteria. 1) danger to self, 2) endangered from others, 3) danger to others, 4) at risk to escape. As an example, this would include a ward that is involved in a group disturbance, and/or serious gang fight or battery.

When wards are assigned to Inyo, their behavior and well-being are monitored daily by staff and the program manager. The assistant superintendent reviews the status of all wards assigned to Inyo each day, using the WIN 2002 system. The assistant superintendent personally makes contact with each ward, and he is aware of the ongoing process to reintegrate the ward back onto a living unit. Managers told the team that the average stay at the Inyo Hall is two to three days before they are returned to their program. This unit was clean and appeared well run. The staff reported the individual secure recreation areas were not in use. A larger, secure recreation area is attached to the Inyo Hall and wards are taken in small groups for outdoor exercise.

The Staff Safety Evaluation Team concurs with the managers, that it is essential for staff and ward safety to continue to operate Inyo as a temporary detention unit. The majority of the wards temporarily housed at Inyo display unpredictable behavior, which can and does manifest into aggressive outbursts. When these wards are removed from the "Open Program", it allows the remainder of the group to continue with their treatment plans, without disruption from wards unwilling to participate in the program.

Finding: Formal orientation training is not provided to non-custody staff prior to their assignments.

Discussion: An additional common theme was the lack of a training officer assigned to the facility. This void directly effected daily operations of OHCYCF. All of the managers stated that newly assigned non-custody staff have not received their required mandatory orientation classes in over two years. The principal specifically expressed concerns with teachers assigned to classrooms at OHCYCF without a single hour of orientation. She stated she attempts to fill this void (when time allows) with on the job training conversations and spot checks. All managers expressed concern with the staffing at OHCYCF. All agreed that the presence of more custody staff would directly affect the behavior of the ward population in a positive manner.

Custody Staff - Interviews with Supervisors

The first and second line supervisors (sergeants and lieutenants) were interviewed at various work locations from August 3 - 5.

Finding: Supervisors concurred with management that the possible closure of Inyo will result in increased assaults, and staff is deeply concerned for their personal safety.

Discussion: With the potential loss of the Inyo program space, the wards will know that staff have no means to control disruptive behavior, as they cannot administer appropriate consequences for rule challenging wards.

Finding: There is a need for additional custody staff, especially on the second watch.

Discussion: The typical staffing pattern requires two staff to be assigned to one hall, unless it is a Sex Offender Program (SOP). Due to operational absences (i.e., staff injuries, illnesses, and scheduled vacations), or vacancies, the senior youth correctional counselor (SYCC) is routinely used to fill a posted position in a hall. During our tours of the halls, we observed supervisors working as the second staff position at numerous halls. In the team's opinion, this results in the SYCC not being able to perform their supervisory responsibilities including: developing and training staff, completing staff work on time, conducting investigations, and preparing staff evaluations.

Additionally, the day-to-day operations require constant ward movement from the hall to exterior programs (i.e., education, dining hall, outpatient housing unit, and recreation). When this movement occurs, floor staff must escort the wards and leaves a single custody officer (YCC) on the housing unit, to supervise up to 30 wards. While the Staff Safety Team was conducting interviews, we were constantly reminded of this issue as we watched wards moving about the institution grounds, without direct supervision from staff and/or grouping together outside of their halls. The Staff Safety Team also observed that approximately 25% of the ward population did not have their identification card properly affixed to their chest for quick identification by staff. When asked why this was being allowed to continue, the response given was that it could not be enforced. On more than one instance, the interview team witnessed wards verbally challenging staff inside open dormitories.

Interviews with Line Staff

The interview team canvassed the institution from August 3 - 5, conducting random interviews with line staff.

Finding: Line staff concurred with the manager and the supervisors that there is a need for additional program space for disruptive wards. All line staff stated the need for additional ward supervision (custody) staff.

Discussion: All line staff voiced the same concerns as the supervisors, as it related to the possible closure of Inyo, and the need for additional staff. Line staff said that an additional staff member is needed in the open dormitories. Line staff said if they have a disruptive ward acting out in these areas, it is difficult to isolate him, because of the open setting. Staff said it is important to control the situation as soon as possible, so other wards don't become physically involved. They reiterated that they would be less likely to take action, if they were the only staff on the hall, because of the potential to be attacked by more than one ward.

Finding: Line staff is concerned about their safety because of the inadequacy of their OC spray for group application.

Discussion: The interview team asked line staff to describe the safety equipment issued to them. As a group, they said they were issued: personal alarms, radios in designated positions, handcuffs, OC spray, and/or CN gas (*A side note*: YCC staff told the team that the OC spray that they are supplied with is only good for a one on one situation, too often they (YCCs) are confronted with group disturbances. They said being allowed to carry Z505 fogger would help in their ability to quell the incident).

Finding: Line staff is concerned about their safety because of the intermittent efficiency of their radios.

Discussion: Staff informed the interview team that they must carry a radio when outside the halls, but they are not required to carry them inside. The interview team noted that in most halls, staff maintained the radios on top of a cabinet or desk, not immediately accessible to staff. When the interview team questioned staff as to why they would not carry a radio as a primary communication device, they told us that the culture at the institution is to rely on their personal alarms, to request assistance in the case of an emergency. Additionally, staff in several halls complained of the batteries for the radios not holding a charge for more than an hour.

Finding: Line staff is concerned about their safety because of the intermittent efficiency of their personal alarms.

Discussion: Staff voiced their concerns about their safety because of the intermittent efficiency of the personal alarms. They told the interview team that depending on their work location; they may have to carry two different personal alarms (i.e., FM frequency or Unisec). They said the FM alarm works in certain halls and buildings, but not outside of the structures. They informed us that the alarm might activate in 75% of the instances that staff may deploy it. Additionally, staff stated that many of the overhead audio monitors in the unit do not work. These units allow the control sergeant to identify and audibly communicate with the unit identified with the alarm situation. The control sergeant verified this concern.

Interviews with Special/Intensive Treatment Programs

These programs are intensified, as they deal with the most difficult and troubled wards. It is essential that there is a sufficient number of qualified and trained staff available at all times to deliver and monitor the program.

Findings: The interview team had the opportunity to spend several hours at each of these locations. During our stay, we observed staff interacting with wards in a positive manner (i.e., acknowledging the ward), while at the same time, being cognizant of safety and security issues.

Finding: Custody staff needs training in how to deal more effectively with mentally ill wards.

Discussion: The SOP staff said, many times, custody staff is assigned to work in the intensified or specialized treatment programs, and they are not familiar with the needs of this population. They suggested that In-Service-Training provide a block of training for all staff, in the identification, recognition, and systematic approach for dealing with mental health issues.

Interviews with Non-Custody Staff

The interview team spoke with non-custody staff from August 3 - 5 at various work locations.

Findings: The teachers would like to see a more visible presence of uniform custody officers, while they are working in a classroom. They also feel that when they report or document wards misbehavior their reports have no clout.

Discussion: Teachers noted that ward movement to and from class is monitored by custody staff, but usually from a distance. Every teacher the interview team spoke with would feel safer if more custody officers were present while the wards filed into and out of the classrooms. Many teachers complained that wards, who are disruptive and challenging, are brought back to their classrooms too soon. This sets a bad example and illustrates the frustration and lack of clout the teachers have in maintaining discipline in their classrooms.

SUMMARY AND CONCLUSION

O.H. Close Youth Correctional Facility (OHCYCF) was the second Division of Juvenile Justice facility to be evaluated by the Staff Safety Evaluation Team, the first being conducted at Preston Youth Correctional Facility (PYCF). There were several issues identified during this evaluation that were common to PYCF, O.H. Close Youth Correctional Facility as well as DeWitt Nelson Youth Correctional Facility and N.A. Chaderjian Youth Correctional Facility which were evaluated immediately following the OHCYCF evaluation.

It is becoming apparent that adequate resources have not been provided to the Division of Juvenile Justice despite the filing of Budget Change Proposals and requests for additional funding (or restoration of funding that fell victim to budget cuts). The lack of resources has negatively impacted staff safety at DJJ institutions. The benign neglect that the team witnessed at PYCF appears to permeate the Institutions and Camps Division.

In a praiseworthy effort to return to the rehabilitative mission of the DJJ, it appears that staff have lost the authority or ability to discipline wards in a meaningful manner. Many wards recognize that there is little consequence for negative behavior and as such, there is an insufficient disincentive for bad behavior. It must be recognized that many of the wards in the DJJ system are adults who happen to have been adjudicated in the Juvenile Court System. DJJ management should revisit the policies for correcting undesirable behavior of wards to ensure that the policies are effective and appropriate for the ward population.

As directed by the Corrections Standards Authority, the findings from this evaluation will be presented to the CSA at their next scheduled meeting and copies of the report will be provided to CSA members, CDCR administration and Assistant Superintendent Matlock. It is outside the scope of this project for the CSA to receive and monitor a corrective action plan and appropriate action will be the responsibility of CDCR Division of Juvenile Justice.

CORRECTIONS STANDARDS AUTHORITY
600 Bercut Drive
Sacramento, CA 95814

July19, 2005

Heyman Matlock, Asst. Superintendent
O. H. Close Youth Correctional Facility
7650 S. Newcastle Road
Stockton, CA95213-9001

Dear Assistant Superintendent Matlock:

CDCR Secretary Roderick Hickman asked the Corrections Standards Authority (CSA) to develop a plan to evaluate staff safety issues in the Division of Adult Institutions and the Division of Juvenile Facilities. At their May 19, 2005 meeting, the CSA unanimously approved a proposal to assemble a panel of subject matter experts to develop criteria for conducting staff safety evaluations.

The panel met on May 24-25, 2005 and established the criteria by which the evaluations will be conducted. As a result, a team comprised of staff from the CSA, Adult Operations and Juvenile Justice will be conducting the evaluations over the next 28 months and will be evaluating staff safety at the Northern California Youth Correctional Center on **August 3-12, 2005.** We expect to be on site for eight days and plan to observe operations during all shifts at all three facilities.

We would like to begin with an entrance conference with you and the superintendents from N.A. Chaderjian and DeWitt Nelson and appropriate administrative staff on **August 3, 2005 at 9:00 a.m.** to discuss the method by which the staff safety evaluations will be conducted and to get a general overview of facility operations and any concerns you may have.

In order to facilitate the process, please provide the following for the evaluation team's use while at O.H. Close Youth Correctional Facility: (The evaluation team may ask for additional resources, depending on the initial assessment.)

- A contact person with whom the team may coordinate their activities (please call or e-mail this information when the contact is identified).

- An office or conference room equipped with a table, chairs, facility map, facility telephone directory and a telephone. The room should be large enough for a team of nine evaluators.

- Access to all levels of staff for short interviews. These interviews can take place at their assigned work areas and we will avoid interrupting their schedules as much as possible.

- Copies of all documentation relative to each incident of staff assault including: Incident Reports for Assaults on Staff (CYA 8.403 Behavior Report; CYA 8.412 Serious Incident Report, CYA Use of Restraint Report); State Compensation Reports (SCIF) generated as a result of each incident; Use of Force Review findings. It would be helpful if all documentation relative to each incident was assembled and then indexed in a binder by incident.

- Completion of the data collection form that was sent via e-mail asking that facility staff code staff assault incident reports for the past year in the identified format, addressing incident information, inmate information and victim(s) information (please provide an electronic copy of this data as soon as practical).

- Summaries of State Compensation Reports (SCIF) for injuries on staff.
  (Summaries are reportedly available from facility Return to Work Coordinator)

- Access to copies of applicable operations manuals.

Supplemental Data Sources –

- Facility Health and Safety Committee Minutes*
  - Grievances, Recommendations, Actions
- Staff Action Grievance (CYA)*
- Daily Operations Report (DOR); Notice of Unusual Incident (NOU) at certain facilities*
- Authorized Equipment and Functionality
- Use of Force Committee Minutes and responses to recommendations*
- Employee Training records including summary of curriculum and attendance for orientation and annual updates for selected areas*
- Corrective Action Plans for previous audits*
- Safety Committee Meeting Minutes and Risk Management Action Plans
- Program descriptions and locations
- Administrative Summary of ward population
- Staffing summary including duty roster, allotted positions, vacancies, leave of absence for over 30 days for all staff.
- Staffing profile summary including age, sex, years of service and ethnicity
- Facility design and current capacity

Upon completion of the on site portion of the evaluation, we would like to schedule an exit conference with you and/or appropriate members of your staff (on or about August 12, 2005). The results of the evaluation will be reported to the CSA at its regularly scheduled meeting and a written report will be forwarded to CDCR Administration with a courtesy copy sent to you.

Thank you in advance for your anticipated cooperation in this matter. If you have any questions, please feel free to contact Jerry Read, Deputy Director (A), at (916) 445-9435 or jread@bdcorr.ca.gov.

Sincerely,

Karen L. Stoll, Executive Director (A)

*= 2004 and 2005 to date

cc: Silvia Huerta-Garcia, Director (A)
Division of Juvenile Facilities

OHCYCF STAFF ASSAULT DATA
June 2004-June 2005

Attachment B

INCIDENT INFORMATION								INMATE/WARD INFORMATION									
IR/SIR#	Date	Time	Day of Week	Site and Location	Type of Assault	Serious Injury	Inmate Weapon	IM#/YA#	Ethnicity	Classification	Rec'd CDC-CYA	Rec'd Inst	Anticipated Rel Date/PBD	Age	Housing Loc	Special Program/ MH Status	Gang
	5/29/2004	1800	Sat.	Gym	Battery	No	Feet	83035	Wht.	Gen'l Pop.	8/19/1999	5/17/2004	Discharged	22	Sierra	Discharged	None
	1/8/2005	20:27	Thurs.	Sierra Dorm	Battery	No	Fists	87739	His.	Gen'l Pop.	6/26/2002	11/24/2004	10/27/2006	19	Sierra	CDC	N. Hisp.
	1/15/2005	8:20	Thurs.	Dining Rm.	Battery	No	Carton	89024	Asi.	Gen'l Pop.	7/1/2003	10/1/2003	7/17/2010	20	Klamath	NACYFC	None
	1/16/2005	943	Fri.	Modoc Dorm	Battery	No	Hands	89618	His	Drug Prog.	1/5/2004	5/12/2004	4/18/2004	20	Modoc	NACYCF	N. Hisp.
	3/17/2005	16:49	Fri.	Sierra Dorm	Battery	No	Fists	86318	His	Gen/ Pop	6/6/2001	12/13/2004	12/6/2006	19	Sierra	CDC DVI	N. Hisp.

ATTACHMENT C

CORRECTIONS STANDARDS AUTHORITY – STAFF SAFETY EVALUATIONS
Institutional Information
LIVING AREA SPACE EVALUATION

FACILITY: O. H. Close Youth Correctional Facility	**TYPE:**	**DATE:** 8-5-05

Building/Housing Unit							**Each Building**			
Location	Cell Type	Design Capacity	# Cells	EACH CELL		Pop on this day	Program/Security Level	Staffing		
				Beds	E Beds			1st	2nd	3rd
Humboldt	Dorm Single	50 1	1 12*	50 1	10	59	Sex offender program.	1	2	3
El Dorado	Dorm Single	50 1	1 12*	50 1	10	44	General population unit. One half of the unit houses mental health wards.	1	2	3
Calaveras	Dorm Single	50 1	1 12*	50 1	10	45	General population unit.	1	2	3
Del Norte	Dorm Single	50 1	1 12*	50 1	10	44	General population unit.	1	2	3
Fresno	Single	1	48	1	0	46	Six month drug treatment program..	1	2	3
Glenn	Dorm Single	50 1	1 12*	50 1	10	46	General population unit.	1	2	3
Inyo	Single	1	19	19	0	10	Temporary detention unit.	1	2	1
Amador	Dorm Single	50 1	1 12*	50 1	10	0	Closed			
Butte	Dorm Single	50 1	1 12*	50 1	10	0	Closed			
Security and Escort								2	2	2

Note:

Cells in Inyo contain a combination unit.

* Singles cells contain a combination unit.

O.H. Close Youth Correctional Facility
August 3 – 12, 2005

Line Staff:

1. What is your current job title?

2. What is your assignment? What are your primary duties (Post Orders)?

3. When did you start working for the department as…?

4. How long have you been assigned to this facility?

5. How many wards do you supervise? What is their program assignment?

6. What safety equipment is issued to you? What safety equipment do you utilize at all times, otherwise have access to, or have to check out from a central location?

7. Do you have a stab vest? Have you been fitted for one? Do you wear it at all times?

8. What is the general condition of your safety equipment?

9. Is the safety equipment issued to you adequate for your job duties?

10. If the answer is no, what additional safety equipment is necessary?

11.On a scale of 1 to 10, with 1 as the lowest score and 10 as the highest score, how safe do you feel working at this facility? Why do you feel that way?

12.Where do you feel the least safe? Can you describe why that is? Where and when do you feel the most safe? How do other staff feel about this?

13.What staff safety issue are you most concerned about? What worries you the most as you are performing your duties?

14.Do you have any general suggestions or comments relating to staff safety?

15.What most would you like to do or see changed to improve staff safety?

16.How often do you see and/or speak with your supervisor? Your supervisor's supervisor? The superintendent?

17.Are protocols in place for emergency responses?

18.(Policy?)What happens when a staff member is assaulted? If the staff person is injured, where do they go for first aid or for emergency treatment in more serious cases? How long might that take? Who investigates? Are criminal charges filed?

Supervisors:

1. How long have you been assigned to this facility as a supervisor?

2. How many years do you have as a supervisor?

3. Have you worked as a supervisor at any other CYA institution?

4. Describe your duties and responsibilities, and how you carry them out during a routine shift.

5. How many staff do you directly supervise?

6. How many do you indirectly supervise?

7. What is the percentage of time (shift) do you spend personally observing your subordinates?

8. Can you describe the safety equipment that is issued to line staff?

9. What safety equipment is issued and carried by your staff?

10. Is there any other safety equipment, which you know of, available for staff's use?

11. If the answer is yes, what is the additional safety equipment and how is it issued?

12. Do you have a stab vest? Have you been fitted for one? Do you wear it at all times?

13. Does your staff have stab vests? Have they been fitted for one? Do you ensure that they wear it at all times?

14. How often do you see your supervisors?

15. How many of your available staff are on overtime? Ordered over? Voluntary?

16. On a scale of 1 to 10, with 1 as the lowest score and 10 as the highest score, how safe do you feel working at this facility?

17. What is your greatest concern about staff safety for your subordinates?

18. What kind of complaints do you get from staff? Are there any patterns that emerge? How do you handle them?

19. What do you do to ensure a safe working environment for your staff?

20. What would you like to do or see changed to improve staff safety and reduce staff assaults?

21. What protocols in place for emergency responses?

22. What happens when a staff member is assaulted? If the staff person is injured, where do they go for first aid or for emergency treatment in more serious cases? How long might that take? Who investigates? Are criminal charges filed?

Managers:

1.How long have you been assigned to this facility as a manager?

2.How many years experience do you have as a manager?

3.Have you been a manager at any other CYA institution?

4.Describe your duties and responsibilities, and how you carry them out during a routine shift.

5.Have often do you walk through the facility to talk with staff and observe general staff safety practices?

6.Can you describe the safety equipment that is issued to line staff? What is available for them to use?

7.Is there any other safety equipment, which you know of, available for staff's use?

8.If the answer is yes, what is the additional safety equipment and how is it issued?

9.How many of your staff have been issued stab vests? How many have been fitted? What is the timeline for issuing vests? Who has been identified to receive them?

10.On a scale of 1 to 10, with 1 as the lowest score and 10 as the highest score, how safe do you feel working at this facility?

11.When considering staff safety, what types of concerns do you have?

12.From your perspective, what carries the greatest potential for staff injury?

13. What might mitigate or reduce staff assaults?

14. What kinds of complaints do you get from staff? Are there any patterns that emerge?

15. Do you have any long range plans to ensure staff safety and to reduce staff assaults?

16. Do you have anyone assigned to monitor staff assaults or track occurrences to identify trends?

17. If you had sufficient resources (money and staff), what changes would you make to your operation to reduce staff assaults or the potential for assaults? Physical plant, service and supply, operational changes and/or staff changes?

18. Have the number of vacancies, SCIF 3301, other leave of absences affected staff safety? Do you have mandated overtime for staff and supervisors?

19. Do you have any staff off duty as a result of an assault? How long? Have you had contact with them while they were off duty?

20. What level of repair is your facility? Have you made requests for service or special projects that affect the level of staff safety? Have those requests been approved?

21. What protocols in place for emergency responses?

22. What happens when a staff member is assaulted? If the person is injured, where do they go for first aid or for emergency treatment in more serious cases? How long might that take? Who investigates? Are criminal charges filed?

Evaluation Team Members
Northern California Youth Correctional Center

Team 1
Staff Interviews:
Robert Takeshta, CSA Field Representative
John McAuliffe, Adult Operations, Correctional Counselor II
Jeff Plunkett, Division of Juvenile Justice, Captain

Team 2
Physical Plant, Staffing and Population:
Gary Wion, CSA Field Representative
Mark Perkins, Adult Operations, Facility Captain
Mark Miller, Division of Juvenile Justice, Lieutenant

Team 3
Facility Profile, Documentation Review and Data Analysis:
Don Allen, CSA Field Representative
Dave Stark, Adult Operations, Lieutenant
David Finley, Division of Juvenile Justice, Major

Robert Takeshta, Field Representative
Corrections Stadards Authority
Phone: 916-322-8346
Fax: 916-327-3317
E-Mail: btakeshta@bdcorr.ca.gov

Gary Wion, Field Representative
Corrections Stadards Authority
Phone: 916-324-1641
Fax: 916-327-3317
E-Mail: gwion@bdcorr.ca.gov

Don Allen, Field Representative
Corrections Stadards Authority
Phone: 916-324-9153
Fax: 916-327-3317
E-Mail: dallen@bdcorr.ca.gov

John McAuliffe, Correctional Counselor II
Adult Operations
Phone: 916-358-2628
Fax: 916-358-2636
E-Mail: john.mcauliffe@corr.ca.gov

Dave Stark, Lieutenant
Adult Operations
Phone: 916-358-2473
Fax: 916-358-2499
E-Mail: dave.stark@corr.ca.gov

Mark Perkins, Captain
Adult Operations
Phone: 916-358-2626
Fax: 916-358-2499
E-Mail: mperkins@corr.ca.gov

Jeff Plunkett, Captain
Division of Juvenile Justice
Phone: 916-262-0802
Fax: 916-262-1767
E-Mail: jplunkett@cya.ca.gov

David Finley, Major
Division of Juvenile Justice Division
Phone: 805-278-3710
Fax: 805-278-1499
E-Mail: dfinley@cya.ca.gov

Mark Miller, Lieutenant
Division of Juvenile Justice Division
Phone: 209-274-8394
Fax: 916-262-1525
E-Mail: mmiller@cya.ca.gov