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JUVENILE JUSTICE MONITORING UNIT

Special Timely Report

Facility:	Lower Eastern Shore Children's Center 405 Naylor Mill Road Salisbury, MD Phone: 443-523-1520 Superintendent: Michael Berry
Date(s) of Visit:	March 4, 2006 12:00am-1:00am
Visited by:	Katherine A. Perez, Director Kim R. Bones, Juvenile Justice Monitor
Reported by:	Kim R. Bones
Nature of Issues during Reporting Period:	**Overcrowded Conditions** **Staffing Shortage**
Staff Interviewed:	Staff on Duty
Other Agency Involvement:	N/A
Date of Report:	March 28, 2006

INTRODUCTION:

On the above date and approximate time, Katherine Perez, Director of the Juvenile Justice Monitoring Unit (JJMU) and this monitor conducted an unannounced visit to the Lower Eastern Shore Children's Center (LESCC). The facility is a twenty-four bed detention center owned and operated by the Department of Juvenile Services (DJS). LESCC was designed to house eighteen males and six females.

KEY FINDINGS:

Overcrowded Conditions:
The facility's total population was thirty-one including twenty- six males and five females. During the unannounced visit, the monitors found seven youth were sleeping on "boats", similar to a temporary cot on the floor.

DJS Detention Standard 5.1.5, Crowding, The population of each facility shall generally be limited to the architectural design operating capacity. However, the facility shall not be considered crowded as long as the Department can safely and humanely maintain critical aspects of the facility to include the following:

> ***5.1.5.1, The condition of the physical plant, The provision of lighting, heat, plumbing, ventilation, living space, noise levels, and recreational space shall be sufficient to adequately meet the needs of the detained youth.***
> ***5.1.5.4, Youth needs and treatment services, Clothing, proper nutrition, bedding, medical, dental, and mental health care, visitation time, exercise and recreation, and educational and programming services shall be maintained at a sufficient level to accommodate the number of youth in the facility.***
> ***5.1.5.5, Staffing, Staffing levels shall ensure the proper supervision and safety of the residents.***

DJS Standard of Detention 6.5.1, Personal space, No new facilities shall be designed with bedrooms for more than one resident.

COMAR 01.04.04.12, Sleeping Accommodations, Prohibit the use of cots or beds.

The following chart illustrates the facility population:

	# of Youth	Sleeping Assignments	# of Staff
A Pod (6 bedrooms)	5	5 females youth sleeping in individual rooms	1 staff member working both A and B pod.
B Pod (6 bedrooms)	8	5 youth sleeping in single bedrooms 1 youth sleeping in the seclusion room 2 youth sleeping in a handicap room with 1 youth on the bed and 1 youth on a boat	Stated above.
C Pod (12 bedrooms)	18	10 youth sleeping in single bedrooms 2 youth sleeping on boats in 1 bathroom 1 youth sleeping in another bathroom on a boat. 4 youth sleeping in 2 handicap rooms with 2 on beds and 2 on boats 1 youth sleeping in seclusion	1
Control Center	N/A	N/A	1 staff on light duty

A pod (designed to house six youth) consisted of five females.
B Pod (designed to house six youth) consisted of eight males.
C Pod (designed to house twelve youth) consisted of eighteen males.

The monitors observed that the pillow and head one of the youth sleeping in a C Pod bathroom was at the base of the toilet. The staff member stated that these conditions have existed for approximately 2 nights. The staff member stated because the seclusion room is not equipped with a toilet, the youth housed in the bathroom had to be awakened to stand outside and allow for other youth to use the bathroom.

STAFFING:

Two staff members were assigned to supervise the thirty-one youth in the facility. One female staff member supervised both A and B Pods. A male staff member supervised C Pod. A third staff member assigned to the control center is currently on "light duty" due to a wrist injury he suffered on duty in 2005. To date, he has not been medically cleared to work in direct care with the youth. No supervisory staff members were on duty.

Upon entrance to the facility, the monitors observed the female staff member in the control center with the male staff member assigned to work there. It should be noted that the closest staff restroom to the pods is in the control center. While the female staff member was in the Control Center, the youth on A and B Pods were not being supervised. The two staff members assigned to the Pods must leave their youth unattended when taking bathroom breaks and when heating meals for their lunch break. Staff members stated that these working conditions have existed for approximately the past three months. They stated that earlier in the week four youths were admitted to the facility during the overnight shift. The C Pod staff member had to leave his youth unattended while he processed the four youth in the Intake Area.

DJS Procedure Directive #17.III(A), Night Time Supervision, Direct care staff assigned to work the late evening and night shift shall maintain constant supervision of youth by making ten minute checks of individual sleeping rooms throughout their tour of duty. Population counts shall be conducted and documented every ten minutes throughout the tour of duty.

DJS Procedure Directive #17.III(B), Night Time Supervision, Direct care staff assigned to work the late evening and night shift shall be posted in the sleeping area of the cottage/unit to ensure youth are properly supervised and monitored.

DJS Standard of Detention 5.1.5.5, Staffing, Staffing levels that ensure the proper supervision and safety of the residents.

Logbook documentation revealed that a management level staff member worked the overnight shift two nights last week due to the staffing shortage. However, the facility was only staffed with the manager and two other staff members. Overnight shift should consist of one staff member each on all three pods. A shift supervisor should monitor the facility and one staff member should operate the control center.

Detention Standard 5.1.4 states that a control center should provide 24-hour monitoring and coordination of the facility's security, safety, and communication, mechanical, and electrical systems.

This monitor cited the LESCC in a previous report for failing to staff the control center on the overnight shift due to a staffing shortage. In previous monitoring visits, this monitor has observed the Case Manager, a Nurse, and an Administrative Aide operating the control center. Although these staff members

stated that they were trained to operate the controls, they should not be scheduled to work in the Control Center as a replacement for direct care staff. During the March 4th visit, this monitor observed the staff schedule for the week of February 26 – March 4, 2006. The Administrative Aide was scheduled to work on day shift for approximately two days that week. This person should not be included in the direct care staff to youth ratios for that shift.

RECOMMENDATIONS:

1. Youth should be transferred to other detention facilities to avoid overcrowded conditions.
2. Youth should never be required to sleep in facility bathrooms.
3. At least one staff member should supervise each unit during the overnight shift with a supervisor floating between the three pods.
4. One staff member should be assigned to the Control Center.
5. Facility Administrators should request the approval for transportation officers and community case managers to work within the facility to ensure adequate supervision of youth during severe staffing shortages.
6. Staff should be provided time for breaks to allow for bathroom visits, individual meal preparation, etc.
7. Support staff should not be scheduled to work in the Control Center in place of direct care staff.
8. Support staff should not be included in the direct care staff to youth ratios.