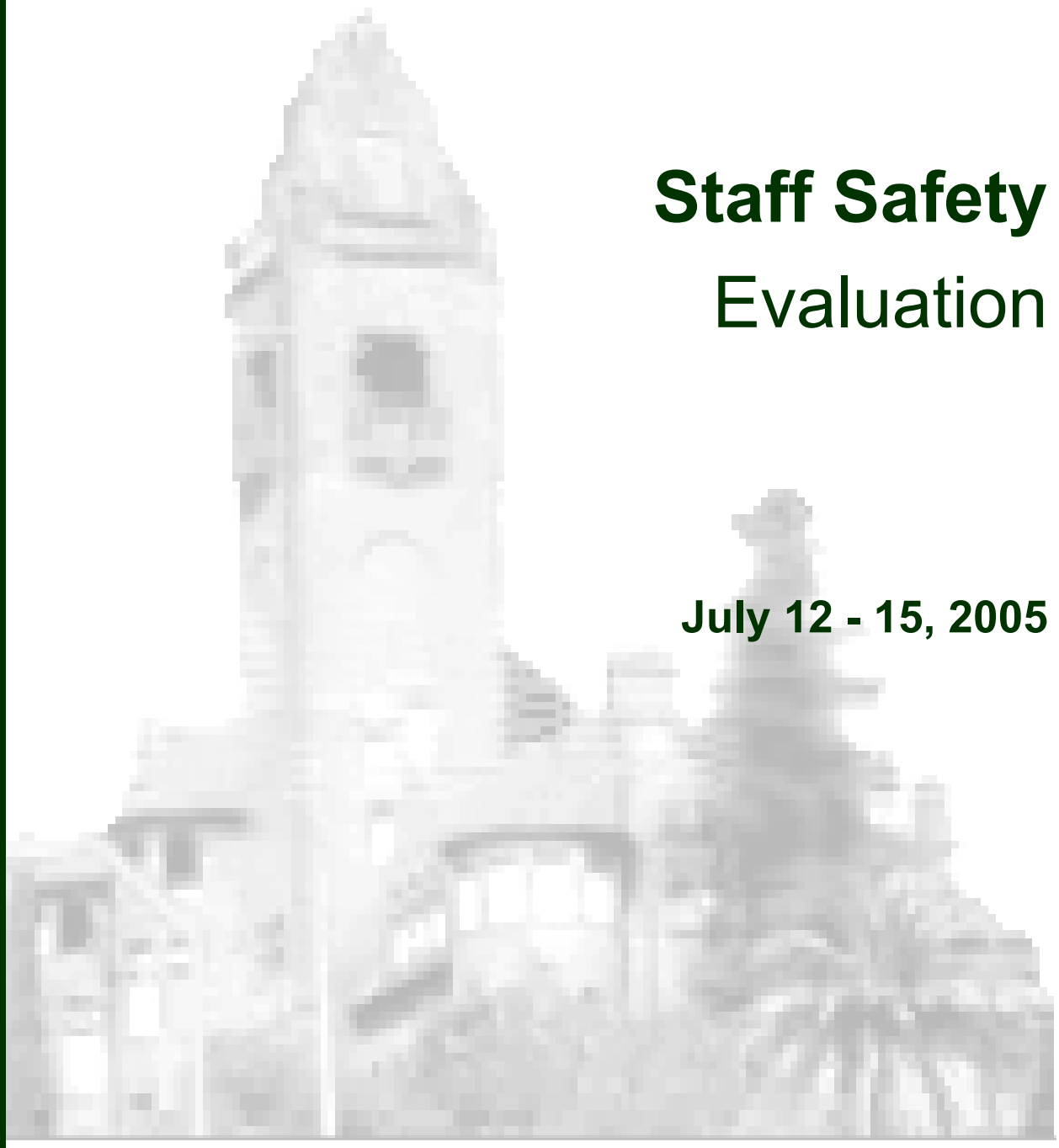
PRESTON YOUTH CORRECTIONAL FACILITY

California Department Of Corrections and Rehabilitation



Staff Safety Evaluation

July 12 - 15, 2005

Corrections Standards Authority
600 Bercut Drive, Suite A
Sacramento, California 95814
www.csa.ca.gov

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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 July 12-15, 2005, a team comprised of staff from the California Department of Corrections and Rehabilitation (CDCR) CSA, Adult Operations and Juvenile Justice Division conducted a Staff Safety Evaluation at the Preston Youth Correctional Facility. The evaluation protocol consisted of a request for advance data on staff assaults 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 and safety equipment.

EVALUATION METHODOLOGY

The Preston Youth Correctional Facility was selected as the first juvenile facility for review and an entrance letter was sent to Superintendent Jay Aguas informing him of the July 12-15, 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 July 12, 2005, at the institution, with an entrance conference with Superintendent Aguas, appropriate institutional administrative staff and evaluation team members. The conference included an operational overview of the institution by Superintendent Aguas as well as an overview of the evaluation process by CSA Field Representative Bob Takeshta.

Using a conference room in the Administrative Building 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, 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 21-25). 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.

An exit conference was conducted with Superintendent Aguas, Assistant Superintendent Tim Mahoney, Chief Deputy Director Silvia Huerta-Garcia, Juvenile Justice Assistant Director of Legislation Eric Csizmar and management staff from O.H. Close Youth Correctional Facility, DeWitt Nelson Youth Correctional Facility and El Paso de Robles Youth Correctional Facility, to provide a summary of the results of the evaluation. The exit conference included a presentation of the team's perceptions and observations as well as a summary of comments made by staff.

FACILITY PROFILE

Preston Youth Correctional Facility (Preston), located 40 miles southeast of Sacramento in Ione, California was initially opened in 1894 as a reform school and accepted their first wards: seven boys previously held in San Quentin Prison. Originally known as "The Preston School of Industry" the building was intended to serve as a progressive action toward rehabilitating youthful offenders, rather than simply imprisoning them in San Quentin. Construction has been ongoing over the years and has included numerous building additions, remodels, and demolitions. Many of the existing structures are over 50 years old. The original building, now a historical landmark known as the "Castle", was vacated in 1960 yet remains overlooking the rolling grounds of the present institution.

Current Usage

With the closure of the Northern Reception Center and Clinic (NRCC) in Sacramento in 2004, Preston became the youth reception center for Northern California. It also houses many youth who are otherwise difficult to place in the youth correction and rehabilitation system.

This facility utilizes a "Normative Culture" program 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. The communities at this facility are not segregated by gang affiliation or by race. There are no fences around the exercise yards. The lodges are either dormitory settings or individual sleeping rooms and are not filled to capacity because the model works best with lower ward populations. One lodge with individual sleeping rooms was configured for "close" security living but was not designated as being administrative segregation housing. Crowding was not an issue at this facility.

Preston is the only youth facility in the state with a Specialized Behavioral Treatment program designed to serve wards in need of a higher level of mental health program treatment by trained mental health staff. Preston has three lodges that house wards with severe emotional and mental health problems in individual sleeping room settings. The three programs include:

- Intensive Treatment Program (ITP) for wards who are acutely disturbed and so impaired they cannot be adequately programmed in other youth programs.

- Specialized Counseling Program (SCP) for wards who exhibit acute social and emotional disturbances at a level greater than can be addressed within other programs.

- Specialized Behavioral Treatment Program (SBTP) for wards with mental health disorders and who act out violently.

Population Summary

The ward population at Preston has fluctuated over the years, depending on numbers of wards in the CYA system and the availability of programs. During peak times such as the 1960's and again in the late 1990's, Preston held as many as 1000 wards. The current capacity, including the closed lodges and recent remodeling, is 789. On the first day of our evaluation, the institution housed 452 wards, including 22 ITP, 40 SCP and 24 SBTP designated youths.

Twenty-five percent of the ward population has been committed for crimes involving sexual assault. Eighty-two percent have documented gang affiliations and eighty-five percent have histories of substance abuse. Forty-eight percent of ward population is Hispanic, twenty-nine percent black, fifteen percent white and eight percent classified as "other". The wards' ages range from 14 to 22 and the average age is 17.1 years.

Staffing Allocation and Availability

Management staff at Preston consists of the Superintendent, an Assistant Superintendent and a Major who is designated the Chief of Security at the facility. On the initial day of our evaluation the funded staffing was established at 209 custody personnel (including the management staff) Program Administrators, Lieutenants, Sergeants, Youth Correctional Counselors, Youth Correctional Officers, Parole Agent I/III, Case Worker Specialists and Medical Technical Assistants (MTA). The Superintendent has identified an additional 18 positions necessary for the operation of the institution. Preston has 3 vacant custody positions and 32 custody personnel are off work or otherwise unavailable for assignment. Of the 214 non-custody position allocations, there are currently 28 vacancies and 6 non-custody employees were off on long-term leave (over 3 months). 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	209	3	32	174
Non-Custody Staff	214	28	6	180
Total	423	31	38	354

It should be noted that these staffing numbers were provided by Preston staff and were not confirmed or reconciled with numbers maintained by Division of Juvenile Justice headquarters.

PHYSICAL PLANT, STAFFING & POPULATION

Preston sits on 264 acres, 64 of which are inside the secure perimeter fence and includes many buildings such as the 13 housing units, administrative offices, educational buildings, vocational shops, and maintenance shops. The facility also has a receiving unit, an infirmary unit, dining hall, kitchen, chapel, a swimming pool and a gymnasium within the secure perimeter. Twelve of the housing units or "lodges" are currently in operation as living areas for wards. The lodges are generally located around the perimeter of the exercise field and gymnasium. Four of the lodges are designed with individual sleeping rooms and the others have open dormitories (see Attachment C for design and current capacities). All of the buildings are separated by such significant distances that search and escort officers must use vehicles to provide services to the lodges.

The outer perimeter area includes several one, two and three bedroom homes available for rent to staff. One ward housing unit, built as an open camp setting, is also located outside of the secure fencing but is now closed.

Staff strategically assigned to posts throughout the facility control ward movement within the secure perimeter. Critical to this function are staff posted in the two towers. Tower One is approximately 100 feet above the ground and Tower Two is approximately 75 feet high. The height of these towers allows for direct visual observation of most of the grounds.

Evaluation staff was unable to identify the classification level of the wards housed within the facility due to the lack of a classification system within the Division of Juvenile Justice.

Educational services are provided onsite within the secure perimeter. There are 43 classrooms. Some of these classrooms are dedicated to vocational education programs. Vocational programs available to the wards include landscaping, masonry, auto mechanics, print shop, janitorial, and computer graphics. Other vocational programs have been eliminated due to budget constraints.

Eight of the twelve lodges have a similar configuration. A dayroom is centrally located within each lodge and shower and restroom areas are located behind an elevated staff area. A dormitory is located adjacent to the dayroom and contains a secure area for the staff assigned to the first watch. Additionally, wards have access to a toilet and washbasin located near the secure staff area within the dormitory. A combination of single, double and triple bunks comprise the bed configurations within each lodge.

The four remaining lodges contain single occupancy sleeping rooms configured in a linear design off the hallway from the dayroom. Each of the sleeping rooms contain an intercom, bunk, toilet and washbasin. The shower area is located off of the dayroom. Each of these lodges contain a small number of rooms equipped with video monitoring systems.

Each lodge has one staff assigned to the first watch, two staff on the second watch and three staff on the third watch. The Ironwood, Sequoia, Redwood, and Oak Lodges have enhanced staffing levels due to the type of programs contained within each.

- Ironwood Lodge contains the wards assigned to the Special Management Program (SMP) and Temporary Detention (TD). Wards on SMP are identified as those with documented behavior problems requiring a restricted program. Wards on TD are those identified as a danger to themselves, to others, endangered, or likely to escape.
- The Sequoia Lodge contains the Specialized Behavioral Treatment Program (SBTP). Wards assigned to this program have been identified as requiring mental health involvement.
- The Redwood Lodge contains minors assigned to the Intensive Treatment Program (ITP).
- The Oak Lodge contains wards assigned to the Specialized Counseling Program (SCP). The SCP targets wards that have committed sexually related offenses.

The following lodges address the needs of different groups of wards as follows:

- The Cedar Lodge contains the orientation program for the younger wards coming into the system from the counties.
- The Ponderosa Lodge contains the orientation program for the older boys.
- The Greenbrier Lodge contains the Preston orientation program for new wards arriving from other Juvenile Justice Division institutions.
- The Buckeye Lodge houses wards assigned to work within the facility. These work assignments include the kitchen and landscaping detail within the secure perimeter.

The remaining lodges are general programming.

The physical plant evaluation team toured the institution, reviewed institutional procedures and interviewed staff of various classifications. 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

FINDING: Some type of transitional intervention program is needed for handling assaultive or violence prone wards.

DISCUSSION: The Tamarack Lodge was closed in March 2004. This lodge contained 64 single sleeping rooms designated to house those wards that had a previous history of assaulting other wards and/or staff. Records indicate that ward on ward assaults prior to the closure of Tamarack averaged approximately 18 per month. Following the closure of Tamarack, these assaults immediately increased and have averaged approximately 61 per month since the closure (see Attachment F).

The closure of the Tamarack Lodge and the corresponding increase in ward on ward assaults have contributed to a safety issue for the staff that are required to intervene during these assaults and for the wards housed at Preston. The Tamarack Lodge provided housing and programming for wards with a history of assaultive behavior that require individual sleeping rooms and specialized programming. Although the Juvenile Justice Division does not provide a system for identifying the level of security for the purposes of assigning housing for wards, the wards placed at Preston are recognized as in need of higher levels of security. Preston is comprised primarily of open dormitories and there is a limited number of single occupancy sleeping rooms available. These beds are committed to wards requiring specialized mental health programs. Although the Tamarack Lodge is very old and in dire need of refurbishing (as is the case for many of the buildings at this facility), some team members are of the opinion that with appropriate modifications, the lodge offers great potential to provide a transitional intervention program and is necessary given the security level of the wards currently housed at Preston.

Tamarack Lodge is not well lit and is painted a dull color. Updating and increasing the lighting and painting the unit a brighter color would alleviate much of the dungeon-like appearance of the building. The room-fronts are not conducive to staff supervision and serve to isolate wards confined in the rooms. The archaic doors would need to be replaced with modern doors equipped with large view panels to increase staffs' ability to monitor the safety of the wards but also reduce the level of isolation and deprivation the rooms currently promote. An additional view panel could also be installed in the wall next to the doors to further increase the sense of openness in the building. The roof over the exercise areas needs to be modified to allow more light into the building. The program spaces would also need to be refurbished to update the areas and make them more consistent with the mission of the Division of Juvenile Justice. While refurbishing would require significant investment, it would be much less expensive than building a new lodge for a transitional intervention program.

In concert with refurbishing, a well-defined program model that would promote desired behavior would need to be developed for the use of the building. Policies would need to be clear as to when this intervention would be used, the maximum length of time that a ward could spend in the program, and levels of review by supervisors, managers, and health professionals to ensure that policies and sound correctional practices were being followed.

Other evaluation team members are of the opinion that the Tamarack Lodge is beyond refurbishing and is not a suitable place for the confinement of wards, regardless of how it is updated. In any event, some type of transitional intervention program is a necessity.

FINDING: Some buildings at the Preston Youth Correctional Facility are over 100 years old. There have been several additions and remodels over the years; however, the current design does not lend itself to the current best practices of managing the incarcerated juvenile population and is not congruent to the mission of the Juvenile Justice Division.

DISCUSSION: Although wards are not formally classified with regard to housing assignments, the management staff within the Juvenile Justice Division has clearly defined the population at this facility as requiring a higher level of security. The security level of the current ward

population is not appropriate for a facility comprised primarily of open dormitories, antiquated infrastructures and living units spread over 64 acres.

The facility design does not lend itself to providing a safe place for staff and wards. Further, the design does not lend itself to a rehabilitative environment. Smaller, self-contained living units with some centralized programming would better fit the needs of the type of ward being held at Preston.

This facility is in need of major upgrades. The current electrical supply is at capacity and will need to be increased. The HVAC systems throughout the entire facility are in need of updating. The open dormitory setting is adequate for wards identified as requiring a lower level of security. With significant upgrades to the infrastructure, the evaluation team felt the facility could possibly be utilized as a vocational training center for wards requiring lower levels of security. However, in the final analysis, the Juvenile Justice Division and the committed wards would be best served by replacing the physical plant rather than attempting to remodel a facility that has exceeded it useful life expectancy.

FINDING: Transportation officers reported that the average vehicle used to transport wards is more than five years old and has odometer readings in excess of 179,000 miles.

DISCUSSION: The Transportation Unit is physically located outside of the secure perimeter at Preston. The transportation unit receives its direction from headquarters and provides transportation of wards to Juvenile Justice Division facilities throughout the state. During the time the evaluation team was onsite (four days), officers experienced mechanical problems with transportation vehicles on four separate occasions while transporting wards. At best, these vehicles are described as unreliable and present an officer safety issue when utilized for transportation purposes. The team was advised that although requests for new vehicles have been made, the requests have not been approved. The team recommends replacing the unreliable vehicles and to establish protocols to replace transportation vehicles at regular intervals.

FINDING: The inventory for hazardous materials is not consistently maintained. There are no visual Material Safety Data Sheets (MSDS) placed on the outside of the cleaning material storage units and additional training and supervision is necessary for wards using the materials.

DISCUSSION: Wards had free access to cleaning materials and were observed mixing different cleaning materials. This is not only unsafe for wards, but the hazardous materials could be used as weapons against staff members. The team recommends placing MSDSs on the exterior of the material storage units; limit ward use of cleaning chemicals; provide additional training and supervision when wards are using the materials; and, maintain consistent inventory of all hazardous materials.

FINDING: There was heavy plant growth between the perimeter fences that could conceal contraband or aid in escapes.

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.

FINDING: High temperatures were noted within each of the lodges.

DISCUSSION: With the exception of Sequoia and Redwood, which house wards prescribed psychotropic medications rendering these wards susceptible to heat related medical issues, all of the lodges are cooled with swamp coolers. Thermometers located within these lodges were observed in excess of 80 degrees during the afternoon hours. While this issue does not have a direct link to staff safety, the frequency of staff assaults was highest during months of the year typically having high temperatures including July, August and September. August was the most notable with 18 incidents occurring, twice that of the nearest comparison month. The team recommends upgrading the air conditioning system in all lodges.

FINDING: A large amount of combustible paper products was noted in ward areas throughout the facility.

DISCUSSION: Evaluation staff was concerned about the potential fire hazard that the accumulation of combustible materials presented and recommend procedures be adopted to reduce the combustible load in ward areas.

FINDING: Due to their temporary detention or special management program status, the wards in the Ironwood Lodge did not have access to the outdoor recreation areas.

DISCUSSION: Staff assigned to this unit said they would be comfortable taking small groups of wards to an outdoor recreation area, providing the area was secure and not too large. Exercise is an important tool in managing wards from both a physical and emotional perspective. The team recommends installing a fence to secure an outdoor recreation area adjacent to the Ironwood Lodge.

Staffing

FINDING: When teaching staff does not report for work for various reasons, a substitute is not brought in (budget issue). As a result, wards are returned to their lodges to wait until the next period to return to the school program.

DISCUSSION: Staffing within the lodge 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 lodge and in school during this time. The evaluation team observed groups of wards, numbering as many as twenty, within the dayrooms of several lodges not attending school during school hours. Supervising these wards creates a safety issue for the lodge staff during this time. The team recommends either increasing the staffing in each lodge 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: Teaching staff indicate that the transfer of information between custody and teaching staff does not always occur in a timely fashion. At times, this information pertains to security issues that affect the entire institution.

DISCUSSION: The team was advised that there is a practice of the Assistant Superintendent or his designee conducting briefings for education staff as necessary; however, management personnel acknowledged that the briefings do not always occur or at least not as timely as they could. The team recommends that formalized process of regular briefings between custody and education staff regarding critical daily operational issues be developed.

FINDING: Post orders provided by staff posted within each lodge were outdated and did not reflect current practice.

DISCUSSION: Of particular concern were post order related to emergency response duties for the staff posted within the lodge. Outdated post orders and uninformed staff lead to a potentially dangerous situation. The team recommends that post orders are updated and training is provided to staff regarding emergency response duties.

FINDING: Hair care service areas are located within the program center. The post orders do not include a regular documented inventory/accounting of the tools used in the hair care area.

DISCUSSION: The team recommends the development of post orders to address inventory of the tools and equipment contained in this area.

Population

FINDING: The Juvenile Justice Division does not utilize a classification system to establish a level of security for housing or facility placement decisions concerning wards.

DISCUSSION: Local adult and juvenile detention facilities and the CDCR Division of Adult Operations utilize a means of identifying those in their care that 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. The team recommends that the Juvenile Justice Division consider developing a system for identifying the security needs of each ward in custody and identify specific housing designed to address the identified 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.

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).
- Staff Assault Review Committee Minutes.
- State Compensation Reports (SCIF) for assaults on staff.
- Safety Committee Meeting minutes including Risk the 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.

Staff Assault Incident Reports

FINDING: After a collective review and discussion of the above listed documents, there were a few notable statistics; however, no obvious trends were identified relative to the issue of staff assaults. Other than ward classification (see discussion below), no issues were identified as being significantly consistent among the various incidents.

DISCUSSION: Fifty-four incidents of battery and attempted battery on staff were reported during the time period, January 1, 2004 through December 31, 2004 at Preston Youth Correctional Facility.

- The victims included employees of several classifications including:
  - 26 Youth Correctional Counselors.
  - 18 Youth Correctional Officers.
  - 3 Lieutenants.

  - 3 Case Worker Specialists.
  - 1 Medical Technical Assistant (MTA).
  - 1 Registered Nurse (RN).
  - 1 Dental Assistant.
  - 1 Doctor.
- The victims included 42 males and 12 females.
- The race of the victims included:
  - 42 white.
  - 6 black.
  - 3 hispanic.
  - 2 reported as "other".

The team was unable to confirm whether the victim demographics were consistent with those of the institution's as those statistics were not readily available. The safety manager reported that over the past three years the average age of all officers filing work related injury reports has been 47 years of age.

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

DISCUSSION: One 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. Hispanic wards were involved in 26 incidents and black wards were involved in 11, a ratio consistent with the facility population. White wards were involved in 16 assaults rather than the expected 6 incidents, if the frequency of incidents were to be reflective of the overall facility population.

The average age of wards involved was 17, the same as the facility population's average age. Seventy-five percent of the wards involved in the incidents have documented gang affiliations, compared to eighty-two percent documented as gang members in the overall facility.

The data describing the length of time in custody may have been skewed depending on the interpretation of the query by the person responsible for completing it. Using the dates of intake provided, it appeared that wards were more aggressive during the initial 9-month period following their arrival at Preston. When asked about a possible explanation, staff said the wards were probably establishing themselves among their peers. Wards do so to prevent being "picked on" or taken advantage of by other wards. In reviewing the data for 2004, the following relationships were noted.

- 0 – 3 months in custody: 17 wards were involved in assaults.
- 3 – 6 months in custody: 10 wards were involved in assaults.
- 6 – 9 months in custody: 5 wards were involved in assaults.
- 9 – 12 months in custody: 0 wards were involved in assaults.
- 12 months or longer: 18 wards were involved in assaults.

FINDING: Hours of the day and months of the year may be factors in assaults on staff.

DISCUSSION: The frequency of incidents was highest during the third watch with 39 occurrences while none occurred during first watch. The frequency of incidents was highest during months of the year typically having high temperatures including July, August and September. August was the most notable with 18 incidents occurring, twice that of the nearest comparison (see the discussion concerning lodge temperatures in the Physical Plant section of this report). The days of the week with the greatest number of incidents were Monday and Saturday and the remainder of the incidents was divided among the other days of the week.

FINDING: Wards with serious mental health issues are more likely to commit assaults on staff.

DISCUSSION: Thirty-seven of the fifty-four incidents involved wards with serious mental health issues. Twenty-nine of the incidents occurred in Sequoia Lodge, which houses a maximum of 24 wards in the Specialized Behavioral Treatment Program (SBTP). Admission into the program is limited to only those wards diagnosed with serious mental health disorders and who have a recent history of acting out violently. Only 7 incidents involved wards on general program status.

FINDING: Ward manufactured weapons were not a factor in assaults on staff.

DISCUSSION: A sharpened stabbing instrument (ward manufactured weapon) was utilized in two of the incidents reviewed. Wards threw an unknown liquid substance on staff in 17 of the incidents. Wards spit on staff in 6 of the incidents. In one of the incidents, a rock was used as a weapon. In the remainder of the 24 cases reviewed, wards used their hands to batter or attempt to batter staff.

FINDING: Data on the subject of staff assaults is difficult to capture and analyze. Reporting of staff assaults needs to use similar reporting criteria. A central tracking system for incidents, particularly regarding staff assaults, would provide more meaningful data and trends may be identified as a result.

DISCUSSION: The definition of staff assault is dependent on the rules of the agency to which the information is being provided. The definition of staff assault for Cal-OSHA, risk management and the courts are all different. The requirements range from the victim being off work, to being slightly injured, to having no injuries sustained and lastly, the unlawful touching or attempt to touch a staff person is sufficient to be considered a staff assault.

The tracking of each type of assault uses a different method and may be compiled by different personnel. A budget analyst maintains some data; other data is maintained by the safety officer and yet other information by the court liaison officer. Tracking may be done based on a calendar year as compared to a fiscal year. Recent changes over the past year yielded some skewed data when comparing time periods.

FINDING: Injuries do not appear to be initially well documented.

DISCUSSION: In the Serious Incident Reports reviewed from calendar year 2004, 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 the following statistics:

- Thirty-eight staff are currently off work on long term leave (more than 3 months).
  - Twenty-one have no return to work date or are pending retirement as a result of their injuries.
  - Thirty are off work as a result of injuries sustained on duty.
  - Thirty-two are custody staff.
  - Fourteen are off as a result of staff assault, responding to emergencies, or injuries sustained while taking action necessary at the scene of an emergency.

In the first six months of 2005, 20 incidents of staff assault have resulted in 23 claims of injury. Some officers have cumulative injuries; one supervisor was injured three times before the injuries were severe enough to be off of work.

FINDING: Depleted staff levels have resulted in mandated overtime.

DISCUSSION: As previously stated, 32 custody staff are off work for an extended period as a result of injuries incurred while on duty (IOD). The absent officer must be backfilled as well as officers off work for training, vacation, sick and annual leave. Managers explained that the need for overtime backfill stemmed from increased sick leave usage following a change in the employment contract.

When the Northern Reception Center and Clinic (NRCC) was closed in 2004 and the reception process was moved to Preston, several staff members were also transferred to Preston. As a result, Preston is overstaffed by 29 custody personnel. Even with the additional staff, significant incidents of mandatory overtime have occurred in the last fiscal year to backfill for the absent officers and to meet the minimum staffing levels. Most notably, in June 2004 and again in May 2005, about 150 staff including Youth Correctional Officers and Youth Correctional Counselors were mandated to work overtime by inverse seniority. To accommodate the need and to prevent exhausted officers from having a traffic accident following a mandated shift, two sleeping rooms have been set up in the administrative area. The issue is a concern in both hard-dollar costs as well as the potential hidden costs of increased worker compensation claims, increased sick leave usage and effects on employee morale.

Preston has 28 vacancies among the allotted 214 non-custody positions. Additionally, 6 non-custody employees were off on long-term leave (over 3 months). Of particular concern, 21 of the 79 educational staff positions are vacant and 3 staff have been relocated to Headquarters. The team was told that due to budget constraints, teachers are not replaced when they are absent from work and the class is cancelled.

FINDING: The safety officer has made significant efforts to promote safety among the staff though additional training in specific areas remains an unfilled need.

DISCUSSION: The safety officer holds regular safety meetings and includes the appropriate persons. Action plans are developed and reviewed at subsequent meetings. She holds contests to promote safety and gives awards to those with the best suggestions. She, as well as other custody staff, attend meetings with medical staff to discuss many issues, including safety issues specifically related to the management of the Specialized Behavioral Treatment Program (SBTP). This program involves wards most likely to commit staff assaults (see later discussion). Statistics provided by the safety officer support the need for increased training in ward relations, officer safety and emergency responses. Reinforcement by supervision at all levels is needed to ensure the information received during the training is applied in the workplace.

FINDING: The Juvenile Justice Division 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, the team was told that the agency had no central classification system. 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 determined at Juvenile Justice headquarters and in consultation with mental health service 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.

A formal system is planned but 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.

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

DISCUSSION: The Institutions Multi-Hazard Emergency Plan (Restricted Emergency Operational Procedures) references the emergency plan review and revision process in a Forward acknowledgement dated January 1, 1980. A copy of these emergency procedures was reviewed; however, it did not contain origination dates, revision dates, or signatures of authority on the specific procedures. Absent of 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 does not account for the staff member's actual location or well being once inside of the institution.

A review of the Facilities Multi-Hazard Emergency Plan for Mutual Aid response revealed that the current procedure (PYC 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 are not referenced in the Multi-Hazard Emergency Plan and were not readily available at the time of request.

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 and institutional orientation training for both custody and non-custody staff. The documentation reviewed was not in compliance with policy. Custody staff was provided 33 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 miscellaneous subjects including: Code of Silence, suicide prevention, drugs and medication, staff/supervisor interaction and disciplinary decision making system.

Custody staff in specific assignments, such as transportation or tactical team (those requiring the use of weapons) require additional training to maintain perishable skills. The firearms training, chemical agent training and baton training are being provided. Supervisors are receiving supplemental training necessary for their positions including restraint chair use, employee substance abuse and hostage situation management.

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.

DISCUSSION: The attendance rate at training appeared to be about 90% among the officers scheduled to attend. Training records only track hours, not which classes were actually attended. No follow up is done to ensure absentees attend the "make-up" classes. 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. He also reported that while training is being offered, supervisors are often unable to release their staff to attend. The staffing is always at a minimal level and overtime is not available to backfill for officers while they are away from their post. When limited resources are available to backfill, supervisors must decide which officers may attend and not release others. As a result, many officers do not receive needed training. With few exceptions, because of mandated overtime, all officers have the potential of working all possible assignments and should receive the appropriate training.

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 ancillary and professional staff having ward contact receive 40 hours orientation training prior to assuming regular duties and 40 hours of annual update training. Clerical support staff with duties not requiring continuous contact with wards are required to receive 40 hours of orientation training prior to assuming their regular duties and 16 hours of update training annually thereafter. 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, he provides a one-hour tour of the facility and one hour of orientation and uses a checklist to document the orientation. He said the initial 40-hour training referred to in the policy was originally provided at the CYA training facility but has since been discontinued. The policy was dated 1999.

The review team interviewed staff throughout the facility. There were concerns from several non-custody employees about not receiving adequate training prior to assuming their positions within the institution. Some employees told the evaluation team that they have been employed at Preston almost a year without receiving orientation 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 no 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 as a result of a change in policy, practice or the law. Such frequent changes make long-term planning difficult. The team provided a copy of the Agency's annual training plan to the Training Manager who said he was aware that one existed but had not personally received a copy. He understood it was still in the development stage and not been operationalized.

FINDING: Training deficiencies at Preston could be improved through better coordination and forming partnerships with other agencies (e.g. Mule Creek State Prison, and other neighboring law enforcement/corrections agencies).

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. The team thought, depending on the subject matter, IIPP training might serve to satisfy both requirements if the programs were coordinated.

The team suggested combining training resources with Mule Creek State Prison, an adult prison located next door to Preston, to provide some of the training. The Mule Creek facility is able to offer a 40-hour orientation class to all employees before they assume their duties. If some of the orientation material is relevant to both facilities, or could be adapted to include both; a partnership may result in more consistent and relevant training to all staff.

The court liaison 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. Partnerships with neighboring law enforcement/corrections agencies including the Mule Creek Facility 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. The alarms are smaller than the radios and the history of wearing an alarm precedes the radio. Three types of alarms are used because not all of the alarms will function properly in all areas of the facility. The rolling grounds, 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. The team recommends replacing the current personal alarm system with one that will provide coverage for the entire facility.

FINDING: Staff were provided radios, however, in most cases the radios were turned off.

DISCUSSION: Staff reported that the practice of maintaining radios in the off position prevented wards from hearing radio communications between the staff. It was explained that this practice prevents the escalation of incidents when the wards "hear" what is happening in other lodges.

Radios offer many advantages (compared to personal alarms) including two-way voice communication between all users and radios function in all work areas. An emergency response can be directed much more precisely and effectively when radio communication is available. The exact location can be radioed to back-up officers as well as any special information needed to ensure a safe response. The team recommends providing a radio earpiece that would allow staff to privately monitor radio communications, stay informed of situations occurring throughout the facility and be available to be contacted via the radio.

FINDING: The Chaplain did not have a personnel alarm or radio. The Chaplain was not aware of duty statements or post orders that provide safety and security guidance to the religious staff working in the chapel. The chapel area did not contain areas clearly marked as out of bounds.

DISCUSSION: All personnel should be required to wear personal alarms (or other communication device) and this policy needs to be reinforced with staff at the facility entrance point. Duty statements or post orders need to be developed for the religious staff to guide them in their duties and responsibilities. The team recognizes that signs cannot be posted at every out-of-bounds area; however, the out-of-bounds area around the chapel is not well defined and the team recommends placing signs in order to better control the movement of wards around the chapel and hold them accountable for noncompliance.

FINDING: A Supervising Case Work Specialist was not carrying personal safety items (pepper spray, hand cuffs, FM alarm, or radio)

DISCUSSION: Management and supervisors must ensure that all staff carry required safety equipment with them at all times. This is an issue of staff safety for the employee in question and also impacts the safety of the other staff, either from having an unequipped staff person who could not render adequate aid, or staff having to come to the aid of an employee who fell victim due to being ill-prepared.

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 spray and latex gloves. Respirators are available in all living units, security vehicles and are issued to individual staff assigned to special teams. Tactical team members and the medical transportation team members are issued batons. 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 team recommends that because the facility is so large and many of the buildings occupied by wards are not living units; some consideration be given to issuing safety items to officers rather than 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: The number of incidents of staff assault are more frequent in three living units where vests are not available than in the living unit where vests are mandated.

DISCUSSION: Only the officers assigned to the Ironwood Lodge (see attachment C) are issued soft body armor stab resistant vests and a supply of vests is stored in the lodge 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.

Five incidents of staff assault occurred in the Ironwood Lodge during the year of 2004. An equal number occurred in the hospital ward, 8 occurred in the Redwood lodge and 27 occurred in the Sequoia lodge. These statistics support the immediate issuance of vests to officers assigned to Sequoia lodge and suggest that strong consideration be given to issuance of vests to all officers. Vests should be available to visitors in Sequoia and Redwood Lodges.

STAFF INTERVIEWS

The Staff Safety Evaluation Team conducted random interviews with custody staff, Intensive Treatment Program staff, and non-custody staff at the Preston Youth Correctional Facility from Tuesday, July 12 through Friday, July 15. 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 in Attachment D).

The team conducted random interviews with Preston staff, on the first, second, and third watches at the following lodges: Arbor, Buckeye, Cedar, Evergreen, Greenbrier, Hawthorne, Ironwood, Manzanita, Oak, Outpatient Housing Unit, Ponderosa, Redwood, and Sequoia. Interviews were also conducted at the gymnasium and education classrooms. Custody staff classifications interviewed included: major, lieutenant, sergeant, youth correctional officer, youth correctional counselor, and medical technician assistant. The Intensive Treatment Program interviews included senior psychologists, psychologists, treatment team supervisors, supervising case work specialists, case work specialists, senior youth correctional counselors, and youth correctional counselors. Non-custody staff interviewed included the medical physician, psychiatrists, supervising registered nurse, registered nurses, vice principal, teachers, chaplain, cook, office technician, and warehouse staff.

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

Custody Staff - Interview with Major/Chief of Security

The interview team met with the Facility Major, who is also the Chief of Security, on July 15, and asked him to describe his concerns for staff safety at Preston. He prefaced his response by saying that the ward population has dramatically changed at Preston. He said more than 82% of the wards claim gang affiliation, they demonstrate violent behavior towards other wards and staff, and are not concerned about consequences for violating the institutional rules.

FINDING: There is a crucial need to have adequate programming space for assaultive wards.

DISCUSSION: When asked about solutions to reduce staff assaults, the major said that ward behavior should drive the program needs. He said behavior modification is an important tool, and if wards constantly step outside the program boundaries, they should be held accountable for their actions. The major said that in the past, if a ward committed a level three offense (i.e., serious rule violation), he could be moved to the Tamarack program, which provides wards with a structured setting. He added that after a ward successfully completed the program at Tamarack, the ward would be transitioned to the Ironwood program for 60 days, which provided the ward with group and individual counseling, in a more open, less restrictive setting than the program at Tamarack. After the ward completed this program, he would move back to an open dormitory setting. The major said that the transition from Tamarack, to Ironwood, to the open

dormitory reinforced the expected norms at Preston, and the wards seemed less likely to become involved in a future rule violation offense.

The major indicated that after the Tamarack program closed, the violence quotient for ward on ward assaults and ward on staff increased dramatically. He said the primary reason for the increase in violence was because the wards could only be removed from their dormitory setting for a few days, due to the lack of an alternative programming area. The wards knew they would be returned to their dormitory, as Tamarack was closed and Ironwood did not have available rooms. This knowledge seemed to empower the wards, as they knew they could retaliate against their rivals upon their return, or challenge staff without fear of being locked up for their behavior.

Supervisors and line staff concurred with the major that the closure of Tamarack (e.g. single cells, which housed assaultive and disruptive wards from the main population) has resulted in increased assaults, and staff is deeply concerned for their personal safety. With the loss of the Tamarack program space, it is the opinion of staff, that the wards know that "staff have their hands tied", as they cannot administer appropriate consequences for rule challenging wards.

Custody Staff - Interviews with Supervisors

The first and second line supervisors (sergeants and lieutenants) were interviewed at various work locations from July 12–15.

FINDING: Supervisors need to supervise and not be utilized to backfill line positions. Additional custody staff, especially on the second watch, is needed.

DISCUSSION: The typical staffing pattern requires two staff (e.g., two youth correctional counselors, or one youth correctional officer and one youth correctional counselor) to be assigned to one lodge, unless it is an Intensive Treatment Program (ITP). Due to operational absences (i.e., staff injuries, illnesses, and scheduled vacations), or other vacancies, the senior youth correctional counselor (SYCC) is routinely used to backfill a line position in a lodge. During our tours of the lodges, we observed supervisors working as the second staff position at numerous lodges. In the team's opinion, this results in the SYCC not being able to perform supervisory responsibilities including supervising and directing, developing and training staff, completing staff work on time, conducting investigations, and preparing staff evaluations.

FINDING: Using lodge officers as escort officers dilutes the staff to ward ratio during heavy movement periods.

Day-to-day operations require constant ward movement from the lodge to exterior programs (i.e., education, dining hall, outpatient housing unit, and recreation). When this movement occurs, lodge staff must escort wards, and this results in only one youth correctional officer or youth correctional counselor left on the housing unit, to supervise up to 30 wards. While the team was conducting interviews, they were constantly reminded of this issue when observing wards moving about the institution grounds, without direct supervision from staff, or loitering together

outside of their lodges. 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 July 12–15, conducting random interviews with line staff.

FINDING: Line staff stated that there is a need for additional staff.

DISCUSSION: Line staff said that an additional staff member is needed in the intake and orientation lodges, as well as the hillside 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 emotionally and physically involved. They reiterated that they would be less likely to take action if they were the only staff on the lodge, because of the potential to be attacked by more than one ward.

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

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 and OC spray (the team noted that staff told us that they do not turn in their OC spray at the end of shift; they keep in their personal possession).

Staff informed the interview team that they must carry a radio when outside the lodges, but they are not required to carry them inside. The interview team noted that in most lodges, staff maintained the radios in a locked office or cabinet, 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 the team that the culture at the institution is to rely on personal alarms to request assistance in the case of an emergency.

However, 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 up to three different personal alarms (i.e., FM frequency, digital, or unicex). They said the FM alarm works in certain lodges and buildings, but not outside of the structures. They indicated that the alarm might activate in 50% to 80% of the instances when staff may deploy it.

To compound this problem, staff said that third watch complains that there are insufficient alarms available for them when they report for duty. Staff said the reason is because of the number of alarms issued out to second watch, and the lack of an adequate number of reserve alarms for the oncoming shift. The interview team was also informed that there are no alarms

assigned to the Hawthorne lodge. Staff is hopeful that an impending upgraded alarm system will alleviate these issues.

Interviews with Special/Intensive Treatment Programs

The interview team conducted interviews with staff assigned to Intensive Treatment Program (Redwood), Specialized Counseling Program (Oak), Special Management Program (Ironwood), and the Specialized Behavioral Treatment Program (Sequoia) from July 12 – July 14.

FINDING: Specialized/Intensive Treatment programs treat the most difficult and troubled wards. It is essential that there are a sufficient number of qualified and trained staff available at all times. Currently, there are not a sufficient number of psychologists onsite to provide treatment for these wards.

DISCUSSION: 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. There appeared to be adequate treatment staff available (Treatment Team Supervisor, Sr. Youth Correctional Counselor, Youth Correctional Counselors, Sr. Casework Specialists, Casework Specialist, and registered nurses); however, there are not a sufficient number of psychologists onsite to provide treatment for these wards.

In interviews with staff, we were informed that two psychologists were assaulted by wards, in separate incidents, while working at the Sequoia Lodge. These psychologists are still not working due to these attacks. As these wards need intensified treatment, it is imperative that this void be filled, as it is unknown if these psychologists will be able to return to work.

FINDING: The recent addition of a staff member in the Sequoia Lodge on weekdays should be designated as a permanent seven day a week post.

DISCUSSION: The interview team was informed that a youth correctional officer is available to assist the second watch in the Sequoia Lodge from 1000-1800 hours Monday – Friday. We were informed that this position was added as a result of litigation (suicide watches). Due to the high volume of ward movement and activities, it would be prudent to fill this post seven days a week.

FINDING: Custody staff needs training on how to deal more effectively with mentally ill wards.

DISCUSSION: The Specialized and Intensive Treatment Program staff said, many times, custody staff are 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 working at Preston 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 July 12 – 15 at various work locations.

FINDING: There needs to be a more visible presence of uniform custody officers while wards are in the classroom moving to and from the classrooms and in the gymnasium.

DISCUSSION: Teachers at every lodge, with the exception of Sequoia and Ironwood, noted that ward movement to class is monitored by custody staff, but usually from a distance. Every teacher the interview team spoke with would feel safer if the custody officer were present while the wards filed into or out of the classrooms. Additionally, at remote locations, such as the gymnasium, the teacher indicated the need for a periodic visit from uniform staff.

FINDING: The nurses working at the specialized and intensive treatment programs felt safer than the nurses assigned to the clinic.

DISCUSSION: The perception of the nurses assigned to the clinic is they feel unsafe when having to dispense medication in the intake, orientation, and open dormitories. The rationale is that custody and treatment staff has less physical control of the wards, and if a ward is acting out, they can break free from staff. The nurses who transferred from the Northern Reception Center and Clinic are also concerned about the physical layout of Preston, as they feel unsafe when they have to walk the vast grounds, while wards are walking unescorted.

SUMMARY AND CONCLUSION

This is the second Staff Safety Evaluation conducted at the direction of the Corrections Standards Authority and the first evaluation of a Division of Juvenile Justice Facility (the first was conducted at Mule Creek State Prison, July 5-8, 2005). It is important to note that the evaluation team concentrated on areas that are not currently being audited by other auditing bodies (e.g.: Office of the Inspector General, Bureau of State Audits, internal compliance monitoring) and the findings should not be considered to be "all encompassing".

While there are a number of deficiencies detailed in this report, many are due to a lack of resources. The team believes that the staff at the Preston Youth Correctional Facility are doing the best they can in many instances with available resources. The physical plant and equipment needs of this facility appear to have been neglected and in the opinion of the team, capital improvements are needed in order to help meet the mission of the Division of Juvenile Justice.

In addition to the capital improvements, training and staffing needs should be further analyzed. It is unfortunate that in trying fiscal times, training resources fall victim to shrinking budgets and the challenge to maintain an adequate number of well-trained human resources grows.

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 Superintendent Aguas. 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.

Attachment A

STATE OF CALIFORNIA
ARNOLD SCHWARZENEGGER, GOVERNOR

BOARD OF CORRECTIONS
600 BERCUT DRIVE, SACRAMENTO, CA 95814

916/445-5073
WWW.BDCORR.C.AGOV

June 27, 2005

Jay Aguas, Superintendent
Present Youth Correctional Facility
201 Waterman Road
Ione, CA 95640

Dear Superintendent Aguas:

The Youth and Adult Correctional Agency (YACA) asked the Board of Corrections (BOC) to develop a plan to evaluate staff safety issues at Department of Corrections (CDC) and Department of the Youth Authority (CYA) detention facilities. At their May 19, 2005 meeting, the Board 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 BOC, CDC and CYA staff will be conducting the evaluations over the next 28 months and will be evaluating staff safety at the Preston Youth Correctional Facility on **July 12-15, 2005.** We expect to be on site for four days and plan to observe operations during all shifts if possible.

We would like to begin with an entrance conference with you and/or appropriate administrative staff on **July 12, 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 Preston Youth Correctional Facility:

- 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 and a telephone in which a team of nine may work.

- 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.

- Incident Reports for Assaults on Staff (CYA 8.403 Behavior Report; CYA 8.412 Serious Incident ReportCYA Use of Restraint Report):
  A data collection form 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).

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

- Access to copies of applicable operations manuals.

The evaluation team may ask for additional resources, depending on the initial assessment. Please keep in mind that Preston Youth Correctional Facility is the first CYA facility for which staff safety evaluations will be conducted, so all needed information is still being determined.

Supplemental Data Sources –
where applicable - to be accessed as needed

- Facility Health and Safety Committee Minutes*
  - Grievances, Recommendations, Actions
- Staff Action Grievance (CYA)*
- Daily Activity Report (DAR); Notice of Unusual Incident (NOU) at certain facilities*
- Authorized Equipment and Functionality
- Use of Force Committee Minutes and responses to recommendations*
- Employee Training records for selected areas*
- Corrective Action Plans for previous audits*

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 July 15, 2005). The results of the evaluation will be reported to the BOC at its regularly scheduled meeting and a written report will be forwarded to YACA 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: Walt Allen, Director
Department of the Youth Authority

Attachment B

Preston Youth Correctional Facility
Staff Assault Data 2004
Page 1 of 2

INCIDENT INFORMATION								INMATE/WARD INFORMATION												VICTIM INFORMATION				
IR/SIR#	Date	Time	Day of Week	Site and Location	Type of Assault	Serious Injury	Inmate Weapon	IM#/YA#	Ethnicity	Classificaton	Rec'd CDC-CYA	Rec'd Inst	Anticipated Rel Date/PBD	Age	Housing Loc	Special Program/MH Status	Gang	Work Assign	Gender	Classificaton (CO/CCII/Cook, etc)	Age	Yrs of Svs	Race
	1/25/2004	17:45	Sunday	Redwood room T1	Pushing object (door) /Stricking face w/ towel	Yes	Hands	87594	Native America	ITP		9/9/2002	5/26/2004	18	Redwood	ITP	Nonaffiliated	None	M	Lt.			White
	4/1/2004	11:50	Thursday	Redwood #C-2	Spit out the cuffing port stricking staff	No	Mouth/Spit	89206	Afr American	ITP		1/2/2004	8/8/2005	14	Redwood	ITP	AfrAm/415/Bay	None	M	YCC			White
	5/16/2004	18:45	Sunday	Ironwood Lodge	Dispersed urine at staff/combative/ physically restrictive	No	Urine	89883	Hispanic	SMP		5/12/2004	Mar-06	18	Ironwood	SMP	Sureno	None	M	YCO			White
	5/23/2004	12:45	Sunday	Sequoia Lodge	Spit on staff	No	Mouth/Spit	85436	Hispanic	SBPT		3/6/2003	7/1/2007	17	Sequoia	SBPT	Nonaffiliated	None	M	YCC			White
	6/14/2004	17:10	Monday	Sequoia Lodge	Threw unknown liquid on staffs arm	No	Ukn liquid	88461	Afr American	SBPT		3/3/2004	4/1/2007	17	Sequoia	SBPT	Blood	None	M	YCC			White
	6/17/2004	6:28	Thursday	Fir Lodge	Striking staff in rib area, shoulder area, an head	No	Battery	89879	Hispanic	Intake		5/18/2004	Mar-06	17	Fir	Intake	Norteno	None	M	YCO			White
	6/30/2004	11:40	Wednesday	Sequoia Lodge	Striking staff in neck, chest and arm with liquid substance	No	Ukn liquid	88250	Hispanic	SBPT		6/2/2003	Mar-07	16	Sequoia	SBPT	Norteno	None	M	YCO			White
	7/1/2004	15:39	Thursday	Redwood Dorm	Struck staff on the left side of forehead with clenched fist	Yes	Battery	89814	Hispanic	ITP		4/14/2004	1/1/2006	18	Redwood	ITP	Bulldog	None	M	YCO			White
	7/6/2004	15:20	Tuesday	Redwood Dorm	Struck staff on the right side of his head with a closed fist	Yes	Battery	89814	Hispanic	ITP		4/14/2004	1/1/2006	18	Redwood	ITP	Bulldog	None	M	YCO			White
	7/7/2004	14:14	Wednesday	Arbor Lodge	Spitting on staff (head, neck, and face)	No	Mouth/Spit	88621	White	General		6/3/2003	11/1/2007	17	Arbor	General	Nonaffiliated	None	M	YCC			White
	7/7/2004	19:55	Wednesday	Arbor Lodge	Stricking with fist to staffs chest	No	Battery	89482	White	General		1/28/2004	Sep-05	16	Arbor	General	Nonaffiliated	None	M	YCC			White
	7/23/2004	16:40	Friday	Ironwood Lodge	Grabbed right wrist of staff through food slot/ pulled arm	No	Battery	87686	Afr American	SMP		12/11/2004	Oct-06	18	Ironwood	SMP	Crip	None	F	YCC			Afr Amer
	7/23/2004	19:58	Friday	Ironwood Lodge	Squirted a white colored unknown liquid on staff	No	Ukn liquid	89879	Hispanic	SMP		5/18/2004	3/1/2006	17	Ironwood	SMP	Norteno	None	F	YCC			Afr Amer
	7/23/2004	20:30	Friday	Ironwood Lodge	Contact with foreign substance to chest and arms	No	Ukn liquid	89879	Hispanic	SMP		5/18/2004/	3/1/2006	17	Ironwood	SMP	Norteno	None	M	YCO			White
	8/9/2004	18:37	Monday	Sequoia Lodge	Battery on Staff and Wards	Yes	Battery	85146	White	SBPT		3/7/2001	11/1/2004	18	Sequoia	SBPT	Skinheads	None	M	YCO			White
	8/9/2004	18:37	Monday	Sequoia Lodge	Battery on Staff and Wards	Yes	Battery	88134	White	SBPT		1/23/2004	5/1/2005	18	Sequoia	SBPT	Peckerwoods	None	M	YCO			White
	8/9/2004	18:37	Monday	Sequoia Lodge	Battery on Staff and Wards	Yes	Battery	89219	Hispanic	SBPT		7/28/2004	11/1/2005	18	Sequoia	SBPT	Sureno	None	M	YCO			White
	8/9/2004	18:37	Monday	Sequoia Lodge	Battery on Staff and Wards	Yes	Battery	85467	White	SBPT		5/31/2001	1/1/2005	16	Sequoia	SBPT	Fresno Peck	None	M	YCO			White
	8/9/2004	18:37	Monday	Sequoia Lodge	Battery on Staff and Wards	Yes	Battery	87363	Hispanic	SBPT		2/21/2003	12/1/2005	18	Sequoia	SBPT	Nonaffiliated	None	M	YCO			White
	8/9/2004	18:37	Monday	Sequoia Lodge	Battery on Staff and Wards	Yes	Battery	89155	Hispanic	SBPT		7/6/2004	10/1/2005	15	Sequoia	SBPT	Norteno	None	M	YCO			White
	8/9/2004	18:37	Monday	Sequoia Lodge	Battery on Staff and Wards	Yes	Battery	87185	Hispanic	SBPT		4/10/2002	9/1/2004	19	Sequoia	SBPT	Nonaffiliated	None	M	YCO			White
	8/10/2004	9:50	Saturday	Sequoia Lodge	Sexually violating staff	No	Battery	89814	Hispanic	SBPT		4/14/2004	1/1/2006	18	Sequoia	SBPT	Bulldog	None	F	DA			White
	8/10/2004	9:50	Saturday	Sequoia Lodge	Battering staff	No	Battery	89814	Hispanic	SBPT		4/14/2004	1/1/2006	18	Sequoia	SBPT	Bulldog	None	M	YCO			White
	8/10/2004	10:45	Saturday	Sequoia Lodge	Battery on Staff w/Foreign Substance (spit)	No	Mouth/Spit	85146	White	SBPT		3/7/2004	11/1/2004	18	Sequoia	SBPT	Skinheads	None	F	CWS			White
	8/10/2004	10:45	Saturday	Sequoia Lodge	Battery on Staff w/Foreign Substance (spit)	No	Mouth/Spit	85467	White	SBPT		5/31/2005	1/1/2005	18	Sequoia	SBPT	Fresno Peck	None	F	CWS			White
	8/11/2004	1:00	Sunday	Ironwood Lodge	Grabbed belt of officer, slamming him into cell door	No	Hands	87360	White	SMP		6/13/2004	9/1/2007	17	Ironwood	SMP	415/Bay	None	M	YCO			White
	8/19/2004	16:50	Monday	Sequoia Lodge	Kicked staff in the elbow	No	Feet	89219	Hispanic	SMP		7/28/2004	11/1/2005	18	Sequoia	SMP	Sureno	None	M	YCO			White
	8/19/2004	16:50	Monday	Sequoia Lodge	Injuried staffs hand while being restrained	No	Hands/Body	89219	Hispanic	SMP		7/28/2004	11/1/2005	18	Sequoia	SMP	Sureno	None	F	CWS			White
	8/24/2004	13:10	Saturday	Redwood Lodge	Stuck staff in the left eye	Yes	Hands	89269	Hispanic	ITP		2/26/2004	11/1/2004	17	Redwood	ITP	Sureno	None	M	YCC			Hispanic
	8/28/2004	17:15	Tuesday	Sequoia Lodge	Threw an unknown type of yellow liquid on staff	No	Ukn liquid	85467	White	SBPT		5/31/2001	1/1/2005	16	Sequoia	SBPT	Fresno Peck	None	M	YCC			White
	8/28/2004	17:15	Tuesday	Sequoia Lodge	Threw an unknown type of yellow liquid on staff	No	Ukn liquid	85467	White	SBPT		5/31/2001	1/1/2005	16	Sequoia	SBPT	Fresno Peck	None	F	YCO			Hispanic
	8/29/2004	14:25	Thursday	Redwood Lodge	Threw unknown liquid on staff	No	Ukn liquid	86322	White	ITP		9/16/2002	11/1/2005	16	Redwood	ITP	Bulldog	None	F	YCC			Afr Amer
	8/29/2004	17:05	Thursday	Sequoia Lodge	Spitting on staff (facial area)	No	Mouth/Spit	87094	Afr American	SBPT		12/19/2002	Dec-05	17	Sequoia	SBPT	Asian Boys	None	M	YCC			White
	8/30/2004	14:45	Friday	Sequoia Lodge	Projected unidentified liquid onto staff	No	Ukn liquid	85146	White	SBPT		3/7/2004	11/1/2004	19	Sequoia	SBPT	Skinheads	None	M	YCC			White
	9/11/2004	19:00	Saturday	Sequoia Lodge	Spit on staffs face	No	Mouth/Spit	89073	Hispanic	SBPT		3/17/2004	11/1/2005	16	Sequoia	SBPT	Norteno	None	M	YCO			White
	9/12/2004	17:47	Sunday	Sequoia Lodge	Attempted battery on staff with wepon	No	Att. Battery	88250	Hispanic	SBPT		6/2/2004	3/1/2007	17	Sequoia	SBPT	Norteno	None	None				
	9/14/2004	7:30	Tuesday	Sequoia Lodge	Threw an unknown substance on staff	No	Ukn liquid	89335	Afr American	SBPT		12/24/2004	7/1/2006	17	Sequoia	SBPT	415/Bay	None	M	YCC			Hispanic

Attachment B

Preston Youth Correctional Facility
Staff Assault Data 2004
Page 2 of 2

INCIDENT INFORMATION								INMATE/WARD INFORMATION											VICTIM 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	Work Assign	Gender	Classification (CO/CCII/Cook, etc)	Age	Yrs of Svs	Race
	9/21/2004	9:30	Tuesday	Sequoia Lodge	Kicked staff in the chest and the groin	Yes	Feet	88784	Hispanic	SBPT		7/3/2004	4/1/2005	17	Sequoia	SBPT	Bulldog	None	M	DR.			White
	9/22/2004	18:30	Wednesday	Evergreen Lodge	Punched staff in the chest/ wreseled around causing injur	Yes	Hands	89875	Hispanic	SBPT		5/13/2004	1/1/2006	17	Evergreen	General	Norteno	None	M	YCC			White
	9/26/2004	17:45	Sunday	OHU/Greenbrier	Threw a rock, striking staff	No	Rock	88606	Afr American	General		3/17/2004	9/1/2005	16	Greenbrier	General	Crip	None	F	MTA			White
	9/26/2004	18:00	Sunday	Manzanita Lodge	Struck staff in the nose and right forehead with fist	Yes	Hands	88675	Afr American	General		3/17/2004	10/1/2005	17	Manzanita	General	Jamacian Mafia	None	M	Lt.			White
	9/28/2004	17:15	Tuesday	Sequoia Lodge	Threw yellow liquid on staff	No	Urine	85467	White	SBPT		5/31/2001	1/1/2005	16	Sequoia	SBPT	Fresno Pek	None	M	YCC			White
	9/28/2004	17:15	Tuesday	Sequoia Lodge	Threw yellow liquid on staff	No	Urine	85467	White	SBPT		5/31/2001	1/1/2005	16	Sequoia	SBPT	Fresno Pek	None	F	YCO			Hispanic
	10/10/2004	7:30	Sunday	Sequoia Lodge	Threw an unknown liquid/possesion of ward made weapo	No	Ukn/wepon	89073	Hispanic	SBPT		12/11/2003	9/1/2006	16	Sequoia	SBPT	Sureno	None	M	YCC			White
	10/10/2004	7:30	Sunday	Sequoia Lodge	Threw unknown liquid/possesion of ward made weapon	No	Liquid/Wea	89703	Hispanic	SBPT		12/11/2003	Sep-06	16	Sequoia	SBPT	Sureno	None	M	YCC			White
	10/12/2004	18:17	Tuesday	Redwood Lodge	Threw unknown liquid/soaked clothing in groin area of sta	No	Ukn liquid	89814	Hispanic	ITP		4/14/2004	1/1/2006	18	Redwod	ITP	Bulldog	None	M	YCC			White
	10/12/2004	18:17	Tuesday	Redwood Lodge	Threw unknown liquid/soaked clothing, groin area of staff	No	Ukn liquid	89814	Hispanic	ITP		4/14/2004	1/1/2006	18	Redwood	ITP	Bulldog	None	M	YCC			White
	10/12/2004	15:20	Tuesday	Sequoia Lodge	Unknown liquid thrown out of food slot	No	Ukn liquid	85436	Hispanic	SBPT		3/6/2003	7/1/2007	17	Sequoia	SBPT	Nonaffiliated	None	M	YCC			White
	10/16/2004	10:47	Saturday	Redwood Lodge	Right knee swelling	No	Hands/Body	89986	Afr American	ITP		9/8/2004	May-08	16	Redwood	ITP	Blood	None	M	YCC			Afr Amer
	11/13/2004	17:15	Saturday	Greenbrier Lodge	Threw a wad of paper and pen at staff	No	Hands	90071	Afr American	General		8/3/2004	Oct-06	15	Greenbrier	General	Nonaffiliated	None	M	YCC			Hispanic
	11/13/2004	17:15	Saturday	OHU	Battery on staff: repeated advancements	Yes	Hands/Body	88534	White	SMP		6/26/2003	6/1/2005	17	OHU	Various	Norteno	None	M	YCC			White
	11/13/2004	17:15	Saturday	OHU	Battery on staff: repeated advancements	Yes	Hands/Body	88534	White	SMP		6/26/2003	6/1/2005	17	OHU	Various	Norteno	None	F	YCC			White
	11/13/2004	17:15	Saturday	OHU	Battery on staff: repeated advancements	No	Verbal	89720	Hispanic	SMP		3/17/2004	2/1/2007	17	OHU	Various	Norteno	None	M	YCC			White
	11/13/2004	17:15	Saturday	OHU	Battery on staff: repeated advancements	No	Verbal	87671	Afr American	SMP		5/6/2003	Jan-07	16	OHU	Various	415/Bay	None	M	YCC			White
	11/18/2004	17:00	Thursday	Sequoia Lodge	Squirted staf with urine and water mixed together	No	Urine	88784	Hispanic	SBPT		7/3/2003	Apr-08	17	Sequoia	SBPT	Bulldog	None	M	YCC			White
	12/9/2004	19:28	Thursday	Oak Lodge	Splashed yellow liquid onto staff	No	Urine	89629	White	General		6/15/2004	1/1/2006	17	Oak	General	Peckerwood	None	F	YCC			Afr Amer
	12/22/2004	12:30	Wednesday	Sequoia Lodge	Threw cup of unknown liquid inot facial area of staff	No	Ukn liquid	88331	White	SBPT		2/28/2003	4/1/2006	17	Sequoia	SBPT	Nonaffiliated	None	F	RN			Phillipine
	12/27/2004	19:10	Monday	Sequoia Lodge	Threw an unknown type of liquid through food slot	No	Ukn liquid	87335	Afr American	SBPT		4/23/2004	9/1/2006	18	Sequoia	SBPT	Crip	None	M	YCC			Afr Amer

CORRECTIONS STANDARDS AUTHORITY – STAFF SAFETY EVALUATIONS

PRESTON YOUTH CORRECTIONAL FACILITY

LIVING AREA SPACE EVALUATION

Building/Housing Unit							Each Building			
Bldg Name	Cell Type	Design Capacity	# Cells	EACH CELL		Pop	Program/Security Level	Staffing		
				Beds	E Beds			1st	2nd	3rd
Arbor	Dorm	55	1	55	0	37		1	2	3
Buckeye	Dorm	55	1	55	0	56	Houses wards assigned to work throughout facility	1	2	3
Cedar	Dorm	65	1	65	0	38	Clinic orientation for younger boys	1	2	3
Evergreen	Dorm	55	1	55	0	44		1	2	3
Ponderosa	Dorm	55	1	55	0	40	Clinic orientation for older boys	1	2	3
Greenbrier	Dorm	55	1	55	0	40	Orientation unit for wards coming to Preston from other YA facilities.	1	2	3
Hawthorn	Dorm	55	1	55	0	40		1	2	3
Ironwood	Single	50	50	50	0	50	Houses wards on temporary detention and Special Management Program. All wet rooms.	2	6	5
Sequoia	Single	50	33	33	0	24	Houses wards on Specialized Behavioral treatment Program. All wet rooms.	2	9	9
Manzanita	Dorm	55	1	55	0	43		1	2	3
Oak	Single	50	43	43	0	39	Houses Specialized Counseling Program, which targets sex offenders. All wet rooms.	2	3	3
Redwood	Single	50	41	45	0	22	Houses wards on ITP program and is the overflow for Oak. All wet rooms.	2	2	3
Fir	Dorm	104	1	104	0	0	Closed	0	0	0
Tamarack	Single	64	64	64	0	0	Closed	0	0	0

Preston Youth Correctional Facility
July 12 – 15, 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?

Attachment E

Evaluation Team Members
Preston Youth Correctional Facility

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

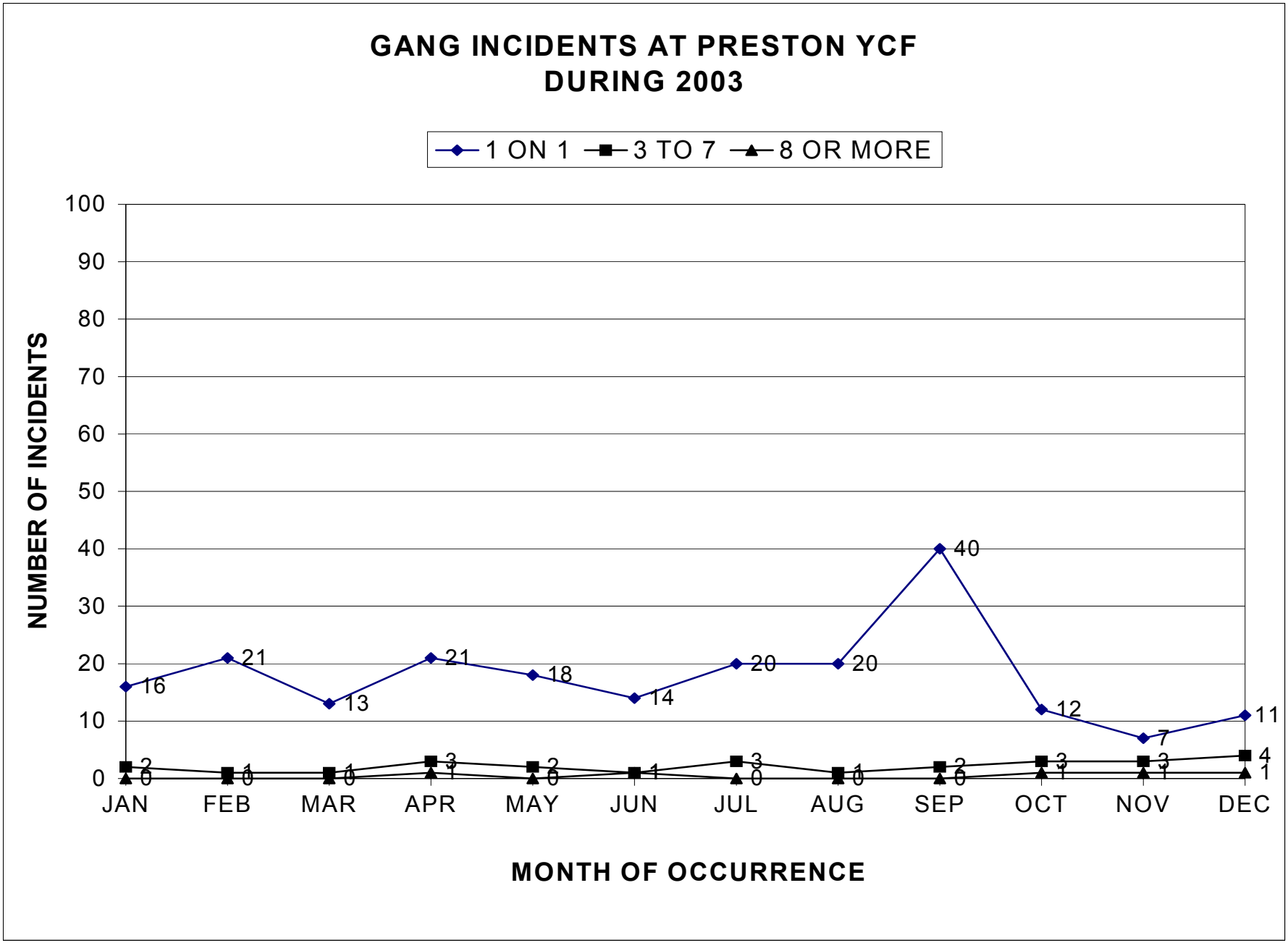
Dave Stark, Lieutenant
Adult Operations
Phone: 916-358-2473
Fax: 916-358-2499
E-Mail: dave.stark@corr.ca.gov

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


GANG INCIDENTS AT PRESTON YCF
DURING 2003
1 ON 1
3 TO 7
8 OR MORE
NUMBER OF INCIDENTS
100
90
80
70
60
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40
30
20
10
0
JAN
FEB
MAR
APR
MAY
JUN
JUL
AUG
SEP
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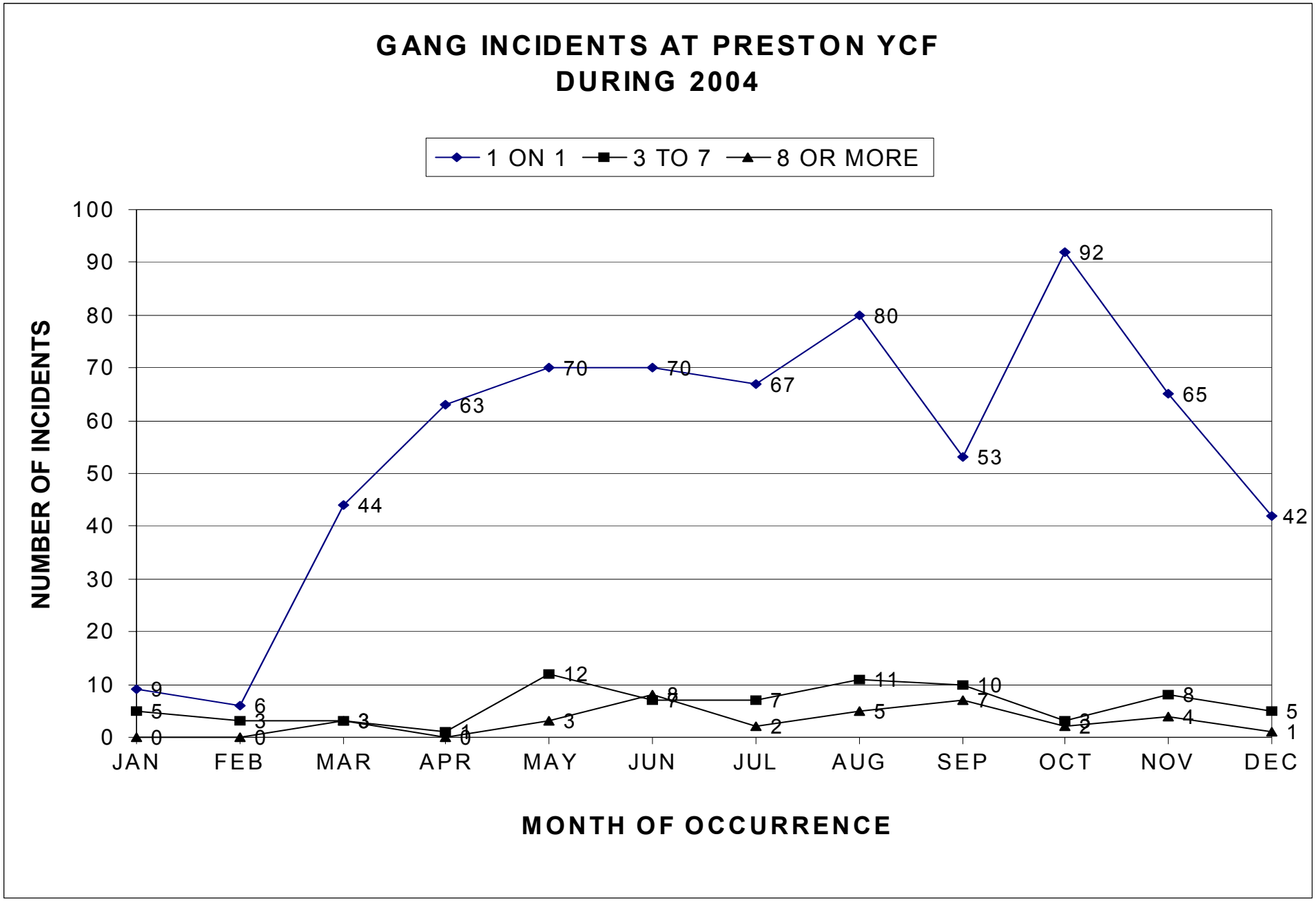
MONTH OF OCCURRENCE


GANG INCIDENTS AT PRESTON YCF
DURING 2004
1 ON 1
3 TO 7
8 OR MORE
NUMBER OF INCIDENTS
100
90
80
70
60
50
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30
20
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JAN
FEB
MAR
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MAY
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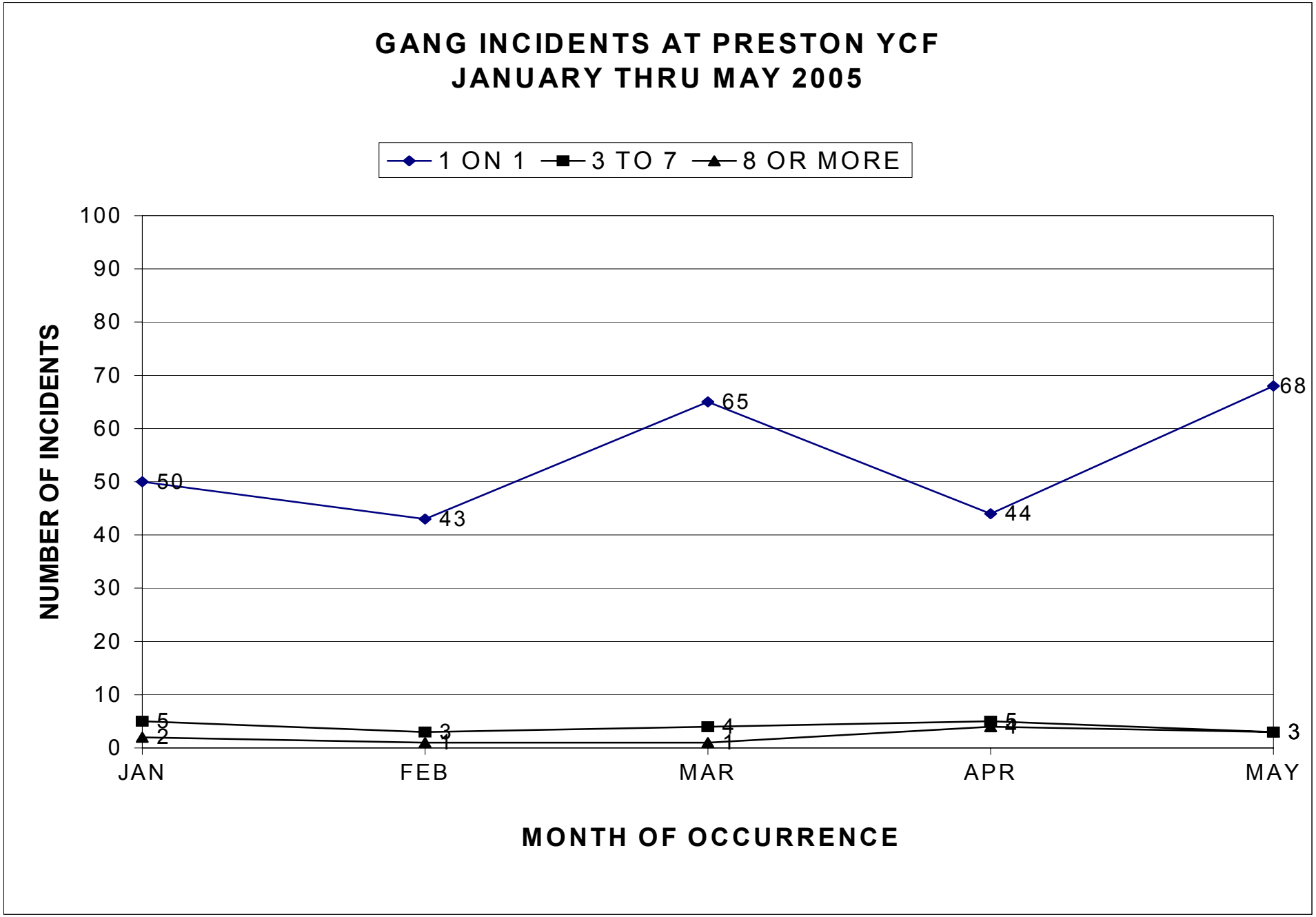
MONTH OF OCCURRENCE


GANG INCIDENTS AT PRESTON YCF
JANUARY THRU MAY 2005
1 ON 1
3 TO 7
8 OR MORE
NUMBER OF INCIDENTS
100
90
80
70
60
50
40
30
20
10
0
JAN
FEB
MAR
APR
MAY
50
43
65
44
68
5
3
4
5
3
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1
4
MONTH OF OCCURRENCE