Maryland Department of
Juvenile Services
Treating • Supporting • Protecting

****REDACTED****[1]

TO: Sheri Meisel
Deputy Secretary of Operations

FROM: Peter J. Keefer
Inspector General (OIG)

DATE: March 15, 2010

Location of Incident: Cheltenham Youth Facility; Murphy Cottage / Re-Direct Program

Involved Staff: Resident Advisor [1]
Resident Advisor [2]
Resident Lead [3]
Resident Lead [4]

OIG Investigators: Robin Brady Slifer, Director of Investigations
Linda M. Beckman, OIG Investigator

INVESTIGATION CONCLUSION:

The Office of the Inspector General, ("OIG") has completed a review of documentation, policies, procedures, and staff statements, and has determined by a preponderance of evidence that on February 17, 2010, Resident Advisors [1] and [2], and Resident Advisor Lead [3] violated Department of Juvenile Services Standards of Conduct and Departmental policies and procedures; therefore these investigations/violations are **Sustained**.

Additionally, review of relevant documentation, policies, procedures, and staff statements, it has been determined by a preponderance of evidence that Resident Advisor Lead

[1] To comply with laws pertaining to employee and youth confidentiality, the Office of the Inspector General has redacted the names of the employees and youth, as applicable. For clarity among the different employees and youth, names have been replaced by a number or letter enclosed in brackets i.e. [1] or [A].

[4] violated Department of Juvenile Services Standards of Conduct and Departmental policies and procedures; therefore this investigation/violations are **Sustained**.

Resident Advisor [1]: Violated Performance of Duties 2.10. / Breach of Security 2.10., DJS policy Youth Movement and Counts RF-02-06 and Supervision and Movement Cheltenham Facility Operating Procedures 004.

Resident Advisor [2]: Violated Performance of Duties 2.10. / Breach of Security 2.10., DJS policy Youth Movement and Counts RF-02-06 and Supervision and Movement Cheltenham Facility Operating Procedures 004.

Resident Advisor Lead [3]: Violated Performance of Duties 2.10.

Resident Advisor Lead [4]: Violated Key Control policy RF-06-05: A1.

INVESTIGATIVE SUMMARY:

On February 18, 2010, the OIG was notified of the death of a staff member while on duty at Murphy Cottage located on the grounds of Cheltenham Youth Facility ("CYF"). OIG commenced an investigation pertaining to operational procedures and policies pertaining to youth supervision, youth movement, and safety/security at Murphy Cottage, and the following information was obtained:

Resident Advisors [1] & [2]

According to Resident Advisor, [1]'s verbal statement to OIG, he was posted at the Murphy Cottage, which is located outside the secure perimeter of the CYF detention facility, on February 17, 2010. At approximately 3:00 p.m. that day, Teacher Ms. Hannah Wheeling requested that youth [1] be sent downstairs to her classroom for testing. Mr. [1] reported that he escorted youth [1] to the top of the steps in the Murphy Cottage, which is the location of the Re-

Direct program. Mr. [1] then allowed youth [1] to proceed down two flights of steps to the classroom without a staff escort or supervision.

At 3:45 p.m., Mr. [1] reported that thirteen youth were escorted by himself and Mr. [2], the other Resident Advisor assigned to Murphy Cottage, to the downstairs game room, which is across the hallway from the classroom. Mr. [1] and Mr. [2] both reported that, at this point, they observed youth [1] sitting in the classroom at a computer desk doing class work. According to Mr. [1], at approximately 3:50 p.m., youth [1] entered the game room from the classroom and he does not recall seeing the youth leave.

According to Mr. [2], at approximately 4:00 p.m., he observed Ms. Wheeling in the Re-Direct classroom while he was standing in the hallway between the classroom and game room talking on his personal cell phone. Mr. [2] also reported that Ms. Wheeling appeared to be preparing to leave from work and that he observed youth [1] sitting at a computer desk towards the back right side of the classroom. Mr. [2] reported that, once he finished his phone call, he went back into the game room leaving youth [1] alone with Ms. Wheeling and that he could not recall when youth [1] returned to the game room.

According to reports by Mr. [1] and Mr. [2], between approximately 4:00 p.m. and 4:10 p.m., Ms. Wheeling came to the doorway of the game room and asked them to identify a volunteer to clean her blackboard. Youth [2] went into Ms. Wheeling's classroom, cleaned the blackboard, and came back into the game room approximately 10 minutes later.

At approximately 5:00 p.m., Case Manager, [A] reported that she observed youth [1] in the hallway near the stairs that lead to the down stairs area (the location of the classroom and game room). Ms. [A] reported that youth [1] was sweaty, red faced, and seemed nervous and that when she questioned youth [1] about why he was upstairs, youth [1] stated "he was looking for Ms. Wheeling." Ms. [A] stated that she assumed youth [1] had just come upstairs from the game room because of his physical appearance (sweaty and red faced) and that she told him to go back downstairs to re-join his group in the game room.

At 5:30 p.m., Mr. [1] and Mr. [2] escorted all of the youth in the Re-Direct program, including youth [1], upstairs for dinner. Mr. [2] reported that prior to escorting all of the youth to dinner, he did observe youth [1] in the game room but he could not recall the time of his observation.

Based on Mr. [2]'s and Mr. [1]'s statements, the evidence reveals that they failed to follow policies and procedures regarding youth supervision and youth movement. Consequently, they were unable to account for youth [1]'s whereabouts and left him and youth [2] unsupervised. Mr. [2] left youth [1] unsupervised after he took him to the top of the stairs at approximately 3:00 p.m. until he observed the youth [1] again at 3:45 p.m. in the classroom. Mr. [1] could not recall youth [1] leaving the game room after observing him at 3:50 p.m. Mr. [2] left youth [2] unsupervised for approximately 10 minutes.

In addition, after Mr. [2] reported seeing Ms. Wheeling between approximately 4:00 p.m. and 4:10 p.m. and based on the timeframes and statements provided by Mr. [1] and Mr. [2], it is determined that youth [1] was out their line of supervision continuously for approximately 60 minutes. This is the timeframe between the last time Mr. [2] reported seeing youth [1] at approximately 4:00 p.m. to the time Ms. [A] reported seeing youth [1] at approximately 5:00 p.m.

Resident Advisor Lead [3]

Mr. [3] reported that, at approximately 11:00 p.m. on February 17, 2010, Ms. [B] and Mr. [C] requested a transport to Central Laundry and he provided the transportation. Mr. [3] stated that upon returning to Murphy Cottage at 11:30 p.m., he inquired about a vehicle parked in the parking lot adjacent to Murphy Cottage. Mr. [3] indicated that Ms. [B] advised him that the vehicle belonged to Ms. Wheeling. He asked if Ms. Wheeling was still in the building and Ms. [B] replied that she had no idea if Ms. Wheeling was still in the building. Mr. [3] reported that he instructed Ms. [B] to go downstairs and check the downstairs classroom. Mr. [3] indicated that Ms. [B] returned and reported that Ms. Wheeling was not in the building.

Based on Mr. [3]'s statements, the evidence indicates that no further action was taken to determine why Ms. Wheeling's vehicle was still parked in the parking lot next to Murphy Cottage well after her normal work hours or whether Ms. Wheeling had left the facility grounds.

Resident Advisor Lead [4]

Through the process of this investigation, Resident Advisor Lead, [4], was interviewed. Ms. [4] advised that she has been in charge of key control at CYF since 2006. Ms. [4] provided the information set forth below.

On November 3, 2008, Mr. [D] resigned as a DJS teacher and failed to return his set of keys to Ms. [4]. The keys that were in Mr. [D]'s possession opened the front and rear doors of Murphy Cottage. Ms. [4] asked Mr. [D] to return to the facility and turn in the keys. Mr. [D] refused. Ms. [4] was later advised by Ms. Wheeling that she met Mr. [D] at an off-site location and he gave her his set of keys to Murphy Cottage. Upon receiving the set of keys from Mr. [D], Ms. Wheeling completed a key request form on December 15, 2008. In the form, Mr. Wheeling sought to replace a broken key given to her by Mr. [D]. Ms. [4] stated that she replaced the broken key for Ms. Wheeling with a new one.

The key request form completed by Ms. Wheeling on December 15, 2008 was subsequently provided to Ms. [4]. The form did not have the required approval from Ms. Wheeling's supervisor or a signature indicating authorization from the facility administrator or designee, which is required by DJS key control policies when issuing a new key. According to Ms. [4], she knew that Mr. [D] had a key for Murphy Cottage and that Ms. Wheeling would enter and exit Murphy Cottage with Mr. [D]. Ms. [4] stated that she checked with the principal of the CYF School at the time, who verbally approved that Ms. Wheeling could have the keys. Nevertheless, verbal approval is insufficient and the policy requires the signatures of both a supervisor and the facility administrator/designee on the request for key form.

This investigation reveals that Ms. [4] failed to ensure that the key request form submitted by Ms. Wheeling on December 15, 2008 was properly approved and authorized as required by Key Control policy RF-06-05: A1.

ADDITIONAL INFORMATION:

All CYF direct care staff are required to receive 22.5 hours of Maryland Correctional Training Commission ("MCTC") approved Safety and Security training through the DJS Professional Development and Training Unit. All of the staff members listed in this report have attended this training. This training includes safety and security considerations when supervising youth during activities, work detail, recreation, and other social activities. It also covers the importance of accurate youth counts and monitoring the location of all juveniles in a facility at all times.

Training documents confirm that Resident Advisor [2] and Resident Advisor [1] have received the required MCTC training as listed above.

During a face-to-face interview with OIG, Mr. [E], a full-time teacher at the Re-Direct program, reported that Ms. Wheeling regularly requested and was allowed to teach youth in her classroom without staff supervision.

Based on the above facts and information discovered in this investigation, the below aforementioned staff have been administratively charged per the DJS Standards of Conduct.

INVESTIGATIVE CHARGES AND SPECIFICATIONS:

STAFF: Resident Advisor [1]

CHARGE 1.0

2.0 Standards of Conduct and Performance

2.10. Performance of Duties

An employee of the Department shall be responsible for his or her own actions, as well as the proper performance of his or her duties. In carrying out the functions and objectives of the Department, an employee shall perform all duties in a manner that will maintain the highest standards of efficiency. Examples of unsatisfactory performance include but are not limited to the lack of knowledge, unwillingness or ability to perform tasks, failure to conform to work standards established for the employee's classification or position or failure to take appropriate action to ensure compliance with Department regulations.

Specifications 1.0: Resident Advisor [1] failed to ensure that he supervised and/or observed youth [1]'s activities when he: (1) left youth [1] unsupervised after he took him to the top of the Re-direct stairs at approximately 3:00 p.m. on February 17, 2010 until he observed youth [1] again at 3:45 p.m. in the classroom; (2) left youth [1] alone with Ms. Wheeling in her classroom at 3:45 p.m. as he was passing the classroom to enter the game room with the other youth; (3) was unaware of youth [1]'s whereabouts when Ms. [A] discovered youth [1] alone, out of the classroom, and in an unauthorized area at approximately 5:00 p.m.

Recommendation 1.0 It is recommended that Resident Advisor [1] be cited with the appropriate disciplinary action.

CHARGE 2.0

2.0 Standards of Conduct and Performance

2.13. Breach of Security

An employee may not take any action or fail to take any action when the action or failure to act causes a breach of security or a potential breach of security jeopardizing:

2.13.1 The physical security or integrity of an institution, or the physical security of any part of an institution or

2.13.2. The safety of any employee, delinquent youth, offender, client, visitor, or member of the public.

Specifications 2.0: Resident Advisor [1] failed to ensure that he properly supervised and/or observed youth [1]'s activities when he: (1) left youth [1] unsupervised after he took him to the top of the Re-direct stairs at approximately 3:00 p.m. until he observed the youth [1] again at 3:45 p.m. in the classroom; (2) left youth [1] alone with Ms. Wheeling in her classroom; (3) was unaware of youth [1]'s whereabouts when Ms. [A] discovered youth [1] alone, out of the classroom, and in an unauthorized area.

Recommendation 2.0 It is recommended that Resident Advisor [1] be cited with appropriate disciplinary action.

STAFF: Resident Advisor [2]

CHARGE 1.0

2.0 Standards of Conduct and Performance

2.10. Performance of Duties

An employee of the Department shall be responsible for his or her own actions, as well as the proper performance of his or her duties. In carrying out the functions and objectives of the Department, an employee shall perform all duties in a manner that will maintain the highest standards of efficiency. Examples of unsatisfactory performance include but are not limited to the lack of knowledge, unwillingness or ability to perform tasks, failure to conform to work standards established for the employee's classification or position or failure to take appropriate action to ensure compliance with Department regulations.

Specification 1.0: Resident Advisor [2] did not ensure that he supervised and/or observed youth [1]'s activity while he was alone with Ms. Wheeling in her classroom. Mr. [2] was on a personal cell phone call during work hours and was not supervising residents of the Re-Direct program as required.

Recommendations 1.0: It is recommended that Resident Advisor [2] be cited with appropriate disciplinary action.

CHARGE 2.0

2.0 Standards of Conduct and Performance

2.13. Breach of Security

An employee may not take any action or fail to take any action when the action or failure to act causes a breach of security or a potential breach of security jeopardizing:

2.13.1 The physical security or integrity of an institution, or the physical security of any part of an institution or

2.13.2. The safety of any employee, delinquent youth, offender, client, visitor, or member of the public.

Specifications 2.0: Resident Advisor [2] failed to ensure that he properly supervised and/or observed youth [1]'s activity while he was alone with Ms. Wheeling in her classroom at 4:00 p.m. In addition, Mr. [2] was on a personal cell phone call during work hours and was not supervising youth as required.

Recommendations 2.0: It is recommended that Resident Advisor [2] be cited with appropriate disciplinary action.

STAFF: Resident Advisor Lead [3]

CHARGE 1.0

2.0 Standards of Conduct and Performance

2.10. Performance of Duties

An employee of the Department shall be responsible for his or her own actions, as well as the proper performance of his or her duties. In carrying out the functions and objectives of the Department, an employee shall perform all duties in a manner that will maintain the highest standards of efficiency. Examples of unsatisfactory performance include but are not limited to the lack of knowledge, unwillingness or ability to perform tasks, failure to conform to work standards established for the employee's classification or position or failure to take appropriate action to ensure compliance with Department regulations.

Specifications 1.0: Resident Advisor Lead [3] was made aware by Ms. [B] that Ms Wheeling's vehicle was in the parking lot adjacent to the Murphy Cottage at 11:30 p.m. on February 17, 2010. Mr. [3] instructed Ms. [B] to check the classroom to determine if Ms. Wheeling was still in the building. Once Ms. [B] reported that Ms Wheeling was not in Murphy Cottage, Mr. [3] took no further action to determine why Ms. Wheeling's vehicle was still parked in the Murphy Cottage parking lot well after her normal work hours or whether Ms. Wheeling had left the facility grounds.

Recommendation 1.0 It is recommended that Resident Advisor Lead [3] be cited with an appropriate disciplinary action.

STAFF: Resident Advisor Lead [4]

CHARGE 1.0

2.0 Standards of Conduct and Performance

2.10. Performance of Duties

An employee of the Department shall be responsible for his or her own actions, as well as the proper performance of his or her duties. In carrying out the functions and objectives of the Department, an employee shall perform all duties in a manner that will maintain the highest

standards of efficiency. Examples of unsatisfactory performance include but are not limited to the lack of knowledge, unwillingness or ability to perform tasks, failure to conform to work standards established for the employee's classification or position or failure to take appropriate action to ensure compliance with Department regulations.

Specifications: Resident Advisor Lead [4] was responsible to ensure that the key request form submitted by Ms. Wheeling on December 15, 2008 was properly approved and authorized as required by Key Control policy RF-06-05: A1.

Recommendations: It is recommended that Resident Advisor Lead [4] be cited with appropriate disciplinary action.

Notwithstanding: even though the allegations made in this investigation were sustained based on a preponderance of evidence, there were other administrative/procedural issues that were identified.

Specifically, unit log books for Murphy Cottage and the Re-Direct program are currently in the possession of the Maryland State Police as potential items of evidence. These unit log books are expected to have information regarding youth and staff movement within Murphy Cottage on the days in question and would be helpful in the OIG's continuing assessment of the practices and procedures at Murphy Cottage. The OIG remains committed to work with law enforcement and not interfere with a criminal investigation. At such time when the Maryland State Police deem appropriate to make the unit log books available, the OIG will commence a review and make findings and recommendations as appropriate.

Listed below are security and safety recommendations:

CYF / Murphy Cottage Safety and Security Recommendations

1. The frequency of unannounced audits of log books, key control procedures, and security protocols should be increased at all DJS facilities.

2. In the event that Murphy Cottage is re-opened, a review should be commissioned to determine the feasibility of radios for staff and installing video cameras in and around the Cottage.

3. In the event that Murphy Cottage is re-opened, education, nursing and behavioral health staff should be required to report to the Gatehouse to communicate their arrival as well as departure from Murphy Cottage. The Gatehouse would then radio Murphy Cottage to inform staff at the building about the arrival or departure of a teacher or nurse. Murphy Cottage staff would, in turn, radio the Gatehouse to confirm. This procedure would apply to all buildings outside of the secure fence including the Shelter.

4. In the event that Murphy Cottage is re-opened, staff assigned to the security post should be required twice during each shift to enter the Cottage and check all areas of the building to ensure the safety and security of youth as well as staff.

5. When a youth is observed in an unauthorized area, staff should be required to communicate via radio or directly to other staff to identify where the youth is supposed to be located and where the youth had been before observation.

6. Heads of departments at CYF should radio the Gatehouse that all staff who are not relieved at the end of their shifts (i.e. education, nursing, behavioral health staff and cooks) have exited their work location at the end of every shift.

7. All education, nursing and behavioral health staff should be required to attend training on security, youth supervision, and other safety protocols.

8. Comprehensive key log audits should continue at all DJS facilities and occur every month at random times. These key log audits should restrict access to keys to only those employees who are properly authorized.

Note: As new information becomes available through the Maryland State Police investigation, the OIG will continue to examine other security/safety issues and issue further recommendations and reports, if needed.