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# **EXECUTIVE SUMMARY**

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### Background and Perspective

The Inspections and Evaluations (I&E) Division of the Office of the Inspector General (OIG) began an inspection of the District of Columbia (District) Department of Human Services (DHS), Youth Services Administration (YSA) in April 2003. YSA is a large agency responsible for a diverse portfolio of service providers and facilities. Consequently, the inspection is being conducted in two parts. Part One and this report cover YSA management, administrative services, and all operations at the Oak Hill Youth Center (OHYC)<sup>1</sup> in Laurel, Maryland. Part Two will cover the remaining major components of YSA and will be reported on separately.

YSA is the District's primary juvenile justice agency. According to its 2001 annual report,<sup>2</sup> YSA provides daily pre-trial and pre-dispositional secure and non-secure detention services to approximately 250 youths charged with delinquency at any given time. Each year, YSA also provides secure confinement, residential placements, and aftercare supervision and services for approximately 600 youths. YSA's stated mission is to empower youths entrusted to its care to become lawful, competent, and productive citizens. It performs this mission by:

- providing an integrated system of care, custody, and services involving youth, families and community;
- holding youths accountable in the least restrictive environment;
- establishing and implementing an individual service plan for each youth which assists in competency development, rehabilitation, and reintegration; and
- promoting public peace and community safety.

YSA has approximately 480 full-time employees, and its fiscal year (FY) 2003 operating budget was approximately \$53 million. The budget consisted of \$39 million in appropriated funds, and \$14 million in federal grants, intra-District funding, and social services block grants.

***The inspection team (team) found many employees who were highly motivated and dedicated to carrying out YSA's mission. Unfortunately, however, the team also found very high employee turnover throughout YSA, particularly at the highest levels of management; poor management of operations and personnel; a significant number of youths testing positive for illegal substances while in YSA's custody; significant safety and security problems; a lack of written policies and procedures; and very low employee morale. The team also found indications of widespread waste and possible fraud, a lack of adequate checks and balances, and a lack of accountability for the use of YSA resources. The team found no significant deficiencies in the education and medical units at OHYC. In fact, the OHYC Academy, which comes under the District of Columbia Public School System, appears to be very well managed and operating successfully.***

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<sup>1</sup> The Oak Hill Youth Center (OHYC) is a secure facility for youths under both short-term and long-term detention. It is located in Laurel, Maryland, and has a court-ordered capacity of 188 males and 20 females.

<sup>2</sup> No annual report was issued in 2002 or 2003.

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### Scope and Methodology

OIG inspections comply with standards established by the President's Council on Integrity and Efficiency, and pay particular attention to the quality of internal control.<sup>3</sup>

The inspection focused on the management and operations of key areas, including compliance with District of Columbia Superior Court mandates, security, transportation, culinary services, social services, case management services, and medical services. The team reviewed YSA's management of environmental health and safety procedures at OHYC. The team also reviewed best practices recommended by the American Correctional Association (ACA)<sup>4</sup> and the operations of secure youth centers in surrounding jurisdictions. The team conducted 123 interviews and observed all major work areas and key work processes. This report contains 45 findings and 95 recommendations.

The Inspector General (IG) issued seven Management Alert Reports (MARs) on the following matters that the team found required the immediate attention of YSA Management and District of Columbia government officials:

- serious fire safety deficiencies, including inaccessible fire extinguishers, a lack of fire drills, and a lack of posted evacuation plans;
- serious breaches of security at entrances at OHYC due to a lack of adequate search procedures, and the employment of security guards without completed criminal background checks;
- deficiencies in the female housing unit that impair the ability of YCOs to effectively maintain the safety and security of residents and to ensure their own safety as well. These deficiencies included a lack of proper security monitoring equipment, insufficient perimeter lighting, a lack of proper communication equipment, and failure to provide all YCOs with keys to resident rooms in the event of an emergency;

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<sup>3</sup> "Internal control" is synonymous with "management control" and is defined by the General Accounting Office as comprising "the plans, methods, and procedures used to meet missions, goals, and objectives and, in doing so, supports performance-based management. Internal control also serves as the first line of defense in safeguarding assets and preventing and detecting errors and fraud." STANDARDS FOR INTERNAL CONTROL IN THE FEDERAL GOVERNMENT, Introduction at 4 (Nov. 1999).

<sup>4</sup> The team consulted "Standards for Juvenile Corrections Facilities," which was published February 2003 by ACA in cooperation with the Commission on Accreditation for Corrections (CAC). ACA and CAC are private, nonprofit organizations that administer the only national accreditation program for all components of adult and juvenile corrections. Their purpose is to promote improvement in the management of correctional agencies through the administration of a voluntary accreditation program and the ongoing development and revision of relevant, useful standards. Founded in 1870, the ACA is the oldest and largest international correctional association in the world. The standards set forth by the ACA provide administrators of juvenile facilities the opportunity to develop a plan for upgrading facilities and procedures in accordance with nationally recognized and respected benchmarks. The juvenile standards assist administrators in working effectively with the courts, legislatures, and the public. The juvenile correctional field is proceeding in a direction that provides more humane conditions in institutions, ensures the safety of staff and offenders, and provides programs and services necessary to assist juveniles in returning to society.

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- a lack of sufficient and reliable communication equipment which threatens overall safety and security and impairs the ability of Youth Corrections Officers (YCOs), transportation officers, treatment team leaders (TTLs), and social services representatives (SSRs) to perform their jobs effectively;
- illegal substances, such as marijuana and phencyclidine (PCP), smuggled into OHYC on a continual basis;
- documentation of 28 vacant and abandoned buildings at OHYC, many of which are unsecured and have been entered and vandalized; and
- employees operating government vehicles without valid state driver's licenses and government motor vehicle identification cards, and YSA vehicles being operated with expired inspection stickers.

Although most YSA employees were cooperative, responsive, helpful, and knowledgeable, the team found some managers less than helpful in providing requested information and explaining or clarifying OHYC operations.

### **Compliance and Follow-Up**

The OIG inspection process includes follow-up with inspected agencies on findings and recommendations. Compliance forms with findings and recommendations will be sent to YSA along with this report of inspection (ROI). The OIG/I&E Division will coordinate with YSA on verifying compliance with recommendations in this report over an established time period. In some instances, follow-up inspection activities and additional reports may be required.

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### FINDINGS AND RECOMMENDATIONS

#### Key Findings

***Long-standing deficiencies in the management of OHYC and in attempts to comply with the Jerry M. Consent Decree continue to plague YSA despite millions spent on consultants.*** (Page 21) Numerous deficiencies documented over the years in consultant reports, most easily correctible, have not been addressed. Many of the same types of problems that resulted in the 1986 lawsuit against the District and the subsequent Court Decree regarding juvenile justice matters still exist 17 years later. In both its operational areas and personnel practices, YSA lacks sufficient internal policies and procedures, internal controls, and a system to ensure management and staff accountability. **Recommendations:** (a) That the Mayor give immediate consideration to removing YSA from DHS and forming a separate, cabinet-level agency whose director would report to the Deputy Mayor for Children, Youth, Families, and Elders (DMCYFE). (b) That the DMCYFE immediately address the most urgent problems cited in this OIG report and in previous reports by paid consultants. (c) That the DMCYFE and Director of YSA fully participate in the Performance-Based Standards system for improving juvenile facilities that has been developed under the sponsorship of the U.S. Department of Justice.<sup>5</sup>

***YSA's use of consultants to help achieve compliance with the Jerry M. Consent Decree has been costly and largely ineffective.*** (Page 27) From 1998 through 2003, YSA spent approximately \$3.6 million on consultants in an effort to bring YSA into sustained compliance with the Decree. These projects often resulted in unauthorized overspending, unfulfilled objectives, and poor agency oversight. **Recommendation:** That the A/YSA, in order to minimize the duplication of previous efforts, coordinate a review and prioritization of all policies, procedures, assessments, and recommendations produced by past consultants, and identify those deliverables that can be salvaged and implemented.

***Illegal substances such as marijuana and PCP are smuggled into OHYC regularly.*** (Page 30) The availability of illegal drugs at OHYC hinders treatment efforts and the recovery of residents with pre-existing substance abuse problems. OHYC staff members allegedly are the primary source of the illegal substances used by youths. A Management Alert Report (MAR 03-I-011, at Appendix 2) addressing these issues was sent to the A/YSA. A copy of the A/YSA's response to the MAR is at Appendix 3. The team will follow up on the A/YSA's progress in correcting the problems cited in the MAR. **Recommendations:** (a) That the A/YSA request that the DHS Office of Investigations and Compliance (OIC) investigate allegations by staff members that YCOs are transporting illegal substances into OHYC. The Director of DHS should report the results of that investigation to the Inspector General, and to other government entities as may be required by District, Maryland, or federal law. (b) That the A/YSA explore the feasibility of implementing a canine drug detection program for illegal substances at OHYC.

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<sup>5</sup> The Performance-based Standards (PbS) system was developed by the Council of Juvenile Correctional Administrators at the request of the Department of Justice to assist youth correction and detention facilities in continuously improving the conditions of confinement and the services provided. PbS is described as a tool that agencies can integrate into existing operations to develop, monitor, and sustain improvement. Details can be found at <http://www.performancebasedstandards.org>.

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***OHYC does not have a substance abuse treatment program as required by the Decree and is in jeopardy of failing to qualify for federal grant funding.*** (Page 32) OHYC has been without a structured substance abuse treatment program since March 2003. The previous vendor chose not to renew its contract because OHYC could not provide the necessary therapeutic environment. Without a treatment program in place, YSA is not eligible to apply for a multi-year federal grant that is awarded by the U.S. Department of Justice. **Recommendation:** That the A/YSA expedite the procurement of a contract to provide drug educational and counseling services as required by the Decree and ensure that YSA is eligible to apply for the federal grant funding.

***Contract security guards allowed serious security breaches at entrances to the OHYC Detention Facility.*** (Page 34) Inadequate searches by security guards jeopardized the safety of OHYC employees and youths, and allowed the entrance of contraband items, including drugs, into the secure detention facility. The control of pedestrians and vehicles entering OHYC's front gate was inadequate and sometimes negligent. A Management Alert Report (MAR 03-I-007, at Appendix 4) addressing these issues was sent to the A/YSA and other District officials. A copy of the A/YSA's response to the MAR is at Appendix 5. The team will follow up on the progress in correcting the problems cited in the MAR. **Recommendations:** (a) That the A/YSA provide adequate policies, procedures, and training for security guards to ensure that proper searches of all bags and packages of visitors and employees entering the secure detention facility are conducted. (b) That the A/YSA provide adequate policies, procedures, and training for security guards to ensure that effective frisk and pat search procedures are conducted on visitors and employees entering the secure detention facility. (c) That the A/YSA ensure that the gatehouse metal detector is operational and in use at all times. (d) That the A/YSA ensure that at least two security guards are present at the perimeter entrance gate and that security personnel adhere to all entrance security procedures. (e) That the A/YSA take immediate action to have the front gate restroom facilities repaired so that guards will not have a reason to leave the post unsecured.

***YSA does not conduct adequate and timely background checks on those employees who have regular contact with youths.*** (Page 37) A number of YSA employees currently working closely with youths have not undergone background checks. Current background check procedures at YSA are limited to a search of Metropolitan Police Department records; YSA does not review national databases or the Central Registry of Crimes Against Children/Sex Offenders. **Recommendations:** (a) That the A/YSA ensure that all current employees with regular contact with youths and all applicants undergo a MPD criminal background check as required by current policy. (b) That the Director of the Department of Human Services propose legislation to the Mayor that would require and fund a complete background check for appropriate OHYC and other YSA employees, to include a check of the records at MPD and surrounding law enforcement jurisdictions, a NCIC check, and a review of the Central Registry of Crimes Against Children/Sex Offenders.

***YSA vehicles are being operated with expired inspection stickers and without semi-annual preventive maintenance checks in violation of District Regulations.*** (Page 39) The team observed vehicles with either no inspection stickers or expired stickers, and vehicles that had not received required, semi-annual preventive maintenance checks. A Management Alert Report (MAR 03-I-006, Appendix 6) addressing these issues was sent to the A/YSA. A copy of the

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A/YSA's response to the MAR is at Appendix 7. The team will follow-up on the A/YSA's progress in correcting the problems cited in the MAR. **Recommendations:** (a) That the A/YSA ensure that all vehicles are properly inspected in accordance with District Municipal Regulations. (b) That the A/YSA discontinue the use of vehicles that do not contain valid inspection stickers. (c) That the A/YSA ensure that semi-annual preventive maintenance checks are conducted on all YSA vehicles. (d) That the A/YSA coordinate with DPW to either increase staffing levels for mechanics assigned to OHYC or allot additional days per week for the DPW mechanic to service and maintain YSA's fleet of vehicles.

***YSA employees are operating government vehicles without valid state driver's licenses and government motor vehicle identification cards.*** (Page 41) Numerous YSA employees authorized to drive District vehicles had not provided validation of their state licenses and D.C. Government Motor Vehicle Driver Identification Cards, while others had expired D.C. Government Motor Vehicle Driver Identification Cards. A Management Alert Report (MAR 03-I-006, Appendix 6) addressing these issues was sent to the A/YSA. A copy of the A/YSA's response to the MAR is at Appendix 7. The team will follow-up on the A/YSA's progress in correcting the problems cited in the MAR. **Recommendation:** That the A/YSA ensure that all vehicle operators maintain current state driver's licenses and D.C. Government Motor Vehicle Identification Cards.

***YCOs and transportation officers lack adequate communication equipment.*** (Page 42) Many YCOs on duty in the housing units do not carry two-way radios, and hard-wired telephones in some YCO offices are inoperative. Officers transporting youths outside of OHYC are not issued two-way radios or cellular telephones. The lack of adequate communication equipment threatens the safety of employees and youths. A Management Alert Report (MAR 03-I-008, at Appendix 8) addressing these issues was sent to the A/YSA. A copy of the A/YSA's response to the MAR is at Appendix 9. The team will follow up on the A/YSA's progress in correcting the problems cited in the MAR. **Recommendations:** (a) That the A/YSA ensure that each YCO on-duty at OHYC has a functional two-way radio for the duration of his or her shift. (b) That the A/YSA ensure that wired telephones are repaired or replaced so that the YCO office in each housing unit has a working telephone. (c) That the A/YSA provide additional telephones in each housing unit (i.e. a phone other than the one in the YCO office) to accommodate the youths' biweekly telephone calls. (d) That the A/YSA ensure that at least one transportation officer in addition to the driver is provided with a radio or cellular telephone in order to communicate with the OHYC security control office or with outside public safety agencies. (e) That the A/YSA discontinue the practice of allowing youths to use telephones in the YCO offices.

***Not all staff members in the social services department of OHYC have a working telephone and voice mailbox.*** (Page 45) Not all of the treatment team leaders and social services representatives at OHYC have telephones in their unit offices and/or functioning mailboxes on the facility's voicemail system. These employees also provide critical, time sensitive information and updates to family members and off-site caseworkers. The lack of a telephone or an operable voice mailbox impedes an employee's abilities to provide responsive care and efficiently interact with all parties that participate in a youth's treatment and rehabilitation. A Management Alert Report (MAR 03-I-008 at Appendix 8) addressing these issues was sent to the A/YSA. A copy of

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the A/YSA's response to the MAR is at Appendix 9. The team will follow-up on the A/YSA's progress in correcting the problems cited in the MAR. **Recommendation:** That the A/YSA ensure that employees in the Social Services Division (treatment team leaders, social services representatives, and their supervisors) have functioning telephones and voice mailboxes.

***Inadequate equipment in the female housing unit impedes YCOs' effectiveness and creates potential hazards.*** (Page 46) YCOs in the female housing unit lacked adequate two-way radios, keys to residents' rooms, and security monitoring equipment. Uncomfortable working conditions and inadequate uniforms further erode the effectiveness of YCOs in this unit. A Management Alert Report (MAR 03-I-009, at Appendix 10) addressing these issues was sent to the A/YSA. A copy of the A/YSA's response to the MAR is at Appendix 11. The team will follow up on the A/YSA's progress in correcting the problems cited in the MAR.

**Recommendations:** (a) That the A/YSA ensure that each YCO on duty in Unit 6 has a functional two-way radio for the duration of his or her shift. (b) That the A/YSA ensure that a working telephone is installed in the YCO security office. (c) That the A/YSA ensure that an emergency buzzer, direct phone line, or other notification device is connected between Unit 6 and the OHYC security control center to provide an alternative means of immediate communication in the event of an emergency. (d) That the A/YSA ensure that all electronic security monitoring equipment is repaired or replaced. (e) That the A/YSA ensure that YCOs keep the metal detector activated at all times, that batteries are installed in the hand scanner, and that the scanner is used in accordance with procedures. (f) That the A/YSA ensure the installation of adequate lighting for the exterior building perimeter. (g) That the A/YSA ensure that sufficient air conditioning and heating are provided in the YCO security office.

***The ratio of youths to YCOs exceeds Decree requirements.*** (Page 50) OHYC often exceeds the 10:1 ratio of youths to YCOs required by the Decree. This leaves YCOs unable to effectively monitor youths' activities and ensure the security and safety of both youths and themselves. **Recommendation:** That the A/YSA take the necessary steps to ensure compliance with the youths-to-YCOs ratio.

***Serious fire safety deficiencies may threaten the safety of residents and employees.*** (Page 51) Fire extinguishers were not readily available, fire drills were not being conducted, and emergency evacuation plans were not posted in critical areas. Also, the locks on housing unit doors have manual locks that require the use of a key, a time-consuming process that could pose a safety hazard in the event of a fire or other emergency. A Management Alert Report (MAR 03-I-010, at Appendix 12) addressing these issues was sent to the A/YSA. A copy of the A/YSA's response to the MAR is at Appendix 13. The team will follow up on the A/YSA's progress in correcting the problems cited in the MAR. **Recommendations:** (a) That the A/YSA ensure that all employees have access to fire extinguishers at all times. (b) That the A/YSA ensure that the fire extinguishers in the gymnasium are removed from the closet and reinstalled on the wall mounts. (c) That the A/YSA ensure that all deficiencies cited by the FEMS Fire Prevention Bureau are abated immediately. (d) That the A/YSA ensure that emergency evacuation plans are posted publicly in all key areas of OHYC. (e) That the A/YSA ensure that fire drills are conducted and documented quarterly as required. (f) That the A/YSA hire a trained Health and Safety Officer or provide adequate training to the designated OHYC employee who conducts monthly fire safety inspections. (g) That the A/YSA explore the feasibility of a central locking

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system for all doors in the residential areas so there can be quick egress in the event of a fire or other emergency. (h) That the A/YSA ensure that all YCOs on duty have a set of keys to all locks on the unit in order to promptly unlock doors in the event of a fire or medical emergency.

***Numerous abandoned buildings at OHYC are unsecured and vandalized.*** (Page 55) Vacant buildings on the grounds of the OHYC have been vandalized and in some instances fires have been set. Many of these unused buildings still have active electrical and water service. A Management Alert Report (MAR 03-I-013, at Appendix 14) addressing these issues was sent to the A/YSA. YSA did not respond to this MAR within the timeframe requested by the IG. **Recommendations:** (a) That the A/YSA ensure that each abandoned building at the OHYC is secured against vandalism and safety risks. (b) That the A/YSA ensure that utility service to unused buildings is disconnected.

***OHYC is not reporting unusual incidents to the DHS Office of Investigations and Compliance as required.*** (Page 59) OHYC is not submitting reports of unusual incidents, such as abuse, neglect, and suspicious injuries, to the Office of Investigations and Compliance (OIC) as required by DHS policy. This prevents DHS from properly tracking, investigating, and resolving unusual incidents at OHYC. **Recommendation:** That the A/YSA develop a system to ensure that all unusual incidents are promptly reported to DHS OIC.

***YSA's fiscal and asset management has many deficiencies.*** (Page 60) The team found numerous deficiencies in YSA's contracting and procurement practices, participation in the D.C. Purchase Card program, and warehouse operations. District stakeholders cannot be assured that all services provided under contracts were delivered or delivered in the most cost effective manner. In addition, YSA's lack of proper oversight of the Purchase Card Program and the OHYC warehouse allows for the possibility of theft and mismanagement of District assets. **Recommendations:** (a) That the A/YSA and the District's Chief Procurement Officer conduct a review and audit of all YSA contracts to ensure compliance with District contracting and procurement regulations. (b) That the A/YSA request that the Office of Contracting and Procurement (OCP) and the Office of the Chief Financial Officer (OCFO) conduct an audit of the D.C. Purchase Card Program at YSA. (c) That the A/YSA implement programs to ensure control and accountability of the warehouse operations, and ensure that qualified employees are in charge.

***Deficiencies within YSA's Information Technology (IT) infrastructure may impair YSA's ability to effectively manage its day-to-day operations.*** (Page 63) YSA's IT staff does not have the knowledge necessary to maintain and troubleshoot the Juvenile Information Management System (JIMS), YSA's mission critical computer application. Furthermore, JIMS cannot generate basic statistical reports that are vital to Decree compliance efforts. **Recommendations:** (a) That the A/YSA expedite meetings of representatives from DHS's Office of Information Systems, the District's Office of the Chief Technology Officer (OCTO), and YSA, to discuss engaging OCTO technical expertise until YSA employees can be sufficiently trained on JIMS. (b) That A/YSA give priority to ensuring that JIMS is made capable of producing all reports necessary for supporting OHYC supervision and tracking of detained and committed youths, as well as statistical information required by the court and other entities with a vested or otherwise appropriate interest in YSA operations. (c) That the A/YSA provide

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all units at OHYC with reliable, secure access to JIMS. (d) That the A/YSA ensure that all JIMS users receive appropriate training and ongoing IT support.

### Security

***YSA does not have adequate policies, procedures, or staff to handle an escape from OHYC.*** (Page 69) There are no written procedures at OHYC that detail the step-by-step process that should be followed in the event of an escape. The team also found that YSA does not have adequate, trained staff at OHYC to be mobilized in the event of an escape. **Recommendations:** (a) That the A/YSA ensure that thorough and complete escape procedures are drafted, implemented, and distributed to all key personnel. (b) That the A/YSA ensure that adequate, trained staff are available at OHYC to be mobilized in the event of an escape.

***YCOs have not had emergency response training.*** (Page 70) YSA does not have written criteria that require YCOs to undergo emergency response training and YCOs do not have hands-on emergency response training. **Recommendations:** (a) That the A/YSA ensure that YCOs receive emergency response training. (b) That the A/YSA ensure that all YCOs receive a copy of the Hazard Continuity and Contingency Plan.

***Youths are not photographed when remanded to YSA's custody.*** (Page 71) Youths are not photographed upon being remanded to the custody of YSA, which prevents YSA employees from accurately identifying youth at OHYC and could hinder efforts to find escapees. **Recommendation:** That the A/YSA ensure that each youth is photographed upon arrival at OHYC, and that a copy of this photograph is filed as required.

***The number and location of physical restraints are not accounted for, and OHYC officials are not effectively monitoring their use.*** (Page 71) Accountability in the use and storage of physical restraints at OHYC is lacking. As a result, YSA cannot ensure that restraints are being used appropriately and with proper authorization. **Recommendation:** That the A/YSA follow established policies and procedures regarding the inventory and use of physical restraints.

***Some OHYC electronic monitoring systems are inoperative.*** (Page 72) The team found several monitoring systems at OHYC inoperative, including systems in the gatehouse and the male and female housing units. The lack of functioning electronic monitoring systems prevents adequate surveillance of secured areas and could allow youths to escape undetected. **Recommendation:** That the A/YSA ensures that all electronic monitoring systems at OHYC are repaired and maintained.

***The door to the gatehouse control booth at OHYC is not secured, which compromises facility security.*** (Page 73) The gatehouse serves as the entrance and exit into the OHYC secured facility, and the door to the gatehouse control booth is in need of repair and remains open and unlocked at all times. Unauthorized persons may gain entry to this area and assist youths in escaping. **Recommendations:** (a) That the A/YSA ensure that the hinges on the gatehouse control booth door are repaired. (b) That the A/YSA develop policies and procedures to ensure

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that the gatehouse control booth door remains locked and secured at all times. (c) That the A/YSA discontinue the storage of physical restraints in the gatehouse control booth area.

***Policy and Procedures Manuals are not available in 9 of 11 youth housing units.*** (Page 75) Only 2 of the 11 housing units have written policies and procedures on site. Many procedures and directives are oral, which creates inconsistency in daily operations.

**Recommendations:** (a) That the A/YSA develop up-to-date policies and procedures that govern daily housing unit operations. (b) That the A/YSA ensure dissemination of the policy and procedures manual to all housing units upon development. (c) That the A/YSA maintain copies of all policies and procedures in a manual that is accessible to all employees and the public. (d) That the A/YSA ensure that policies and procedures are updated and distributed annually as recommended by ACA.

### Youth Services

***Project Hands management is not completing investigative reports within the 10-day requirement stipulated by the Decree.*** (Page 78) The internal, independent office at OHYC responsible for investigating and reporting all allegations of child maltreatment does not issue its investigative reports on time, which is in direct violation of the Decree and exposes the District to financial penalties for non-compliance. **Recommendation:** That the Director of DHS take necessary actions to ensure that the 10-day investigative report requirement is met.

***YSA's drug screening program has serious deficiencies.*** (Page 79) YSA lacks written policies, procedures, and training for the collection of urine specimens, and has not established the "chain of custody" procedures necessary to safeguard the validity of the testing program. Also, accurate records are not kept of urine samples or drug test results. **Recommendations:** (a) That the A/YSA establish written policies and procedures for drug testing, and a training program for collectors of urine specimens. (b) That the A/YSA establish a chain of custody for the urine collection process. (c) That the A/YSA ensure accurate records are kept of the drug screening process.

***YSA staff members are constrained by unrealistic diagnostic and reporting deadlines.*** (Page 81) The 2-week period mandated by the Decree for the development of a youth's Individual Service Plan (ISP) is insufficient to create an accurate initial assessment of a youth's strengths and needs. Many youths enter OHYC with drugs in their systems and are under the influence of one or more drugs during much of the diagnostic period. In addition, ISPs at OHYC must be updated every 30 days. Diagnostic and update timeframes in other jurisdictions are more generous. **Recommendation:** That the A/YSA request a meeting with the court-appointed monitors and the Decree plaintiffs' attorneys to negotiate an extension of the diagnostic timeframe and reporting requirements in order to ease the administrative burden created by the current treatment plan deadlines.

***Administrative support for OHYC treatment team leaders is insufficient.*** (Page 83) Treatment team leaders have not been provided adequate administrative help and spend a disproportionate amount of time on administrative tasks rather than providing individual and group therapy, or working on therapeutic programming for youths in their units. The need for

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additional help is particularly acute on those units that deal with detained youths because the turnover rate is much higher in the detained population compared to that of the committed population. **Recommendation:** That the A/YSA expedite the hiring of additional personnel to adequately support the treatment team leaders.

***Poor communication between departments at OHYC impedes the coordination of services and the treatment of youths.*** (Page 83) Numerous D.C. government agencies, such as the Department of Health, the Department of Mental Health, and the District of Columbia Public Schools, provide services to each youth at OHYC, but YSA does not hold regular monthly meetings attended by representatives from each one of the major agencies. This lack of communication can lead to poor coordination of treatment efforts and the inefficient execution of the various elements of a youth's ISP. **Recommendation:** That the A/YSA Administrator reinstate the practice of convening a meeting of all OHYC department heads on a regularly monthly basis.

***Parent participation in diagnostic and treatment team meetings at OHYC is extremely low.*** (Page 84) The majority of parents do not participate in diagnostic and treatment team meetings due to time and location constraints. Parents and guardians should be key participants in the rehabilitative process, and, when excluded from treatment team meetings, they miss an opportunity to interact not only with their child but also with those OHYC staff members who provide services to their child. **Recommendations:** (a) That the A/YSA procure telephone equipment and service in the room where the weekly treatment team meetings are held so that parents will be able to participate in these meetings via teleconference. (b) That the A/YSA lead an initiative, staffed by members from all of OHYC's major departments, to identify additional ways to improve parent participation in the treatment team process.

***OHYC home visitation policies are not uniformly applied.*** (Page 86) Home visitation privileges are not uniformly granted, which dissuades many youth from working toward their treatment goals and striving for good behavior at OHYC. **Recommendation:** That the A/YSA ensure that the home visitation policy is reviewed and more uniformly applied.

***OHYC does not have a dietician to ensure compliance with nationally recommended daily food allowances.*** (Page 87) OHYC does not have a dietician, and a review of the meals prepared and served at OHYC has not been conducted for a number of years. The Master Menu used to prepare meals at OHYC has not been updated to reflect changes in recommended dietary allowances. **Recommendation:** That the A/YSA hire a full-time dietician or a dietary consultant to review menus and ensure compliance with federally recommended daily food allowances.

***OHYC does not have written policies and procedures for youths who require special diets due to religious dietary standards.*** (Page 88) OHYC lacks a written policy for special diets based upon religious beliefs or other dietary constraints. The absence of a written policy might delay the implementation of special diets for youths who request such diets. **Recommendation:** That the A/YSA seek either internal or external expertise in developing written policies and procedures for dietary plans for youths with religious beliefs that require special diets.

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***The number of special diets approved by medical unit personnel creates a burden for culinary workers.*** (Page 88) At one point during the inspection, 60 of 163 OHYC youths were on special diets for medical reasons. OHYC does not have a dietician to approve special diets and the culinary unit cannot be assured that they are preparing correct special meals based upon these medical alerts. Additionally, due to the number of youths stating their need for a special diet and inadequate food allergy testing, these requests create a burden for the food service staff by increasing the number of special meals they must prepare each day. **Recommendations:** (a) That the A/YSA coordinate with medical unit employees and develop and implement written policies and procedures for youth with special diets. (b) That the A/YSA direct the food service manager and medical unit personnel to review all special diets monthly to ensure that dietary information is current. (c) That the A/YSA direct medical unit personnel to verify youths' medical histories and provide testing of youth for allergens prior to placing them on special diets.

***Large muscle exercises for youths are limited and do not comply with the Decree.*** (Page 90) Youth are not participating in a full range of large muscle exercises, and recreation activities are severely limited by insufficient space and outdoor lighting. **Recommendations:** (a) That the A/YSA direct the Supervisory Recreation Specialist to closely monitor documentation submitted by the Recreation Specialists to ensure compliance with the Decree. (b) That the A/YSA improve the outside lighting throughout the facility to ensure that all youths are able to participate in a range of individual and group activities as mandated.

### **Environmental Health & Safety**

***OHYC does not conduct weekly fire and safety inspections of the food service areas.*** (Page 93) OHYC does not have written policies or procedures requiring weekly fire and safety inspections and could not produce documents verifying that fire and safety inspections of the food service area have been conducted. Without regular fire and safety inspections, YSA cannot ensure the health and safety of youths and employees in the food service areas. **Recommendations:** (a) That the A/YSA develop policies and procedures requiring weekly fire and safety inspections of the food service areas. (b) That the A/YSA provide fire and safety inspection training for the employee(s) responsible for these inspections.

***The Culinary Unit does not have written sanitation policies and procedures.*** (Page 93) The culinary unit did not have copies of federal, state, or local sanitation and health codes for review. The lack of readily available sanitation and health codes leaves the interpretation of codes to each food service employee and could lead to inconsistent implementation and health risks to youths and employees. **Recommendations:** (a) That the A/YSA develop written sanitation policies and procedures for the food service areas. (b) That the A/YSA obtain and distribute to each food service employee copies of applicable sanitation and health codes.

***Food service employees do not undergo annual physical examinations.*** (Page 94) YSA requires all food service employees to undergo a physical examination prior to being hired, but does not have written policies and procedures requiring employees to undergo annual reexaminations. Annual physical examinations ensure that food service employees are in good health and free of communicable diseases, which might be transmitted while preparing or serving food. **Recommendation:** That the A/YSA develop and implement a written policy and

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procedure that requires food service employees take annual physicals at the time of employment to include subsequent annual physical reexaminations.

***OHYC does not maintain a reserve supply of food for emergencies as specified in its Emergency Response Contingency Plan.*** (Page 95) The culinary unit at OHYC is not prepared to provide food in the event of an emergency that required total containment of the facility. Emergency food items have not been procured and the freezer designated for use in the Contingency Plan contained furniture and supply items. **Recommendation:** That the A/YSA expedite the procurement of emergency food items in accordance with the Emergency Response Contingency Plan.

***OHYC has not been inspected for environmental, health, and safety deficiencies.*** (Page 96) The inspection team noted inadequate ventilation and temperature control, leaking pipes, possible electrical code violations, and evidence of rodent infestation. Due to inadequate repairs and maintenance, YSA cannot protect the health and safety of residents, employees, and visitors at OHYC. **Recommendation:** That the A/YSA request an inspection of OHYC by the District of Columbia Office of Risk Management to determine whether there are any hazards to residents, employees, and visitors, and if any measures can be taken to address these hazards.

### Administration

***OHYC is not an accredited youth detention facility.*** (Page 99) Accreditation inspections are conducted by an outside team of peer inspectors, and provide a realistic assessment of the quality of the facility and recommendations for improvement. However, OHYC is not an accredited youth detention facility and has never been inspected by an external entity. There are no District regulations requiring inspection, accreditation, or independent evaluation of the facility. **Recommendations:** (a) That the A/YSA take the necessary steps to have OHYC inspected and evaluated by the ACA. (b) That the A/YSA work with the City Council and the Mayor in proposing legislation requiring OHYC to become an accredited facility.

***The Institutional Review Committee, an important quality assurance mechanism within YSA, is not active.*** (Page 100) YSA's Institutional Review Committee (IRC) was established to serve as a quality assurance mechanism with authority to make final decisions on case management disputes. The IRC should also play a role in evaluating each caseworker's performance. The team found that the IRC is not a standing, active committee and that it has not met for a number of months. **Recommendation:** That the A/YSA immediately reactivate the Institutional Review Committee.

***YCOs are not adhering to time and attendance policies.*** (Page 101) YCOs are not signing the Daily Sign-In/Out Sheets upon arrival to work and upon completion of their tour of duty, which makes it difficult for the Time and Attendance (T&A) Clerk to verify their presence at work on specific dates and the number of hours worked. Failure to adhere to this policy creates a potential for T&A fraud. **Recommendations:** (a) That the Officers-of-the-Day ensure that all YCOs sign the Daily Sign-In/Out Sheets upon their arrival and departure from work. (b) That the Officers-of-the-Day review the Daily Sign-In/Out Sheets for signatures and obtain any missing signatures prior to forwarding the sheets to the T&A Clerk.

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***YCOs are exceeding the 24-hours-per-pay-period limit on working overtime.*** (Page 102) YSA has an internal policy that limits the amount of overtime YCOs can work per pay period to 24 hours. YCOs are consistently exceeding the 24-hour limit and averaging 30-60 overtime hours per pay period. **Recommendation:** That the A/YSA enforce compliance with the 24-hours-per-pay-period limit on overtime worked by YCOs.

***YSA is not complying with follow-up training and staff development programs at OHYC as required by the Decree.*** (Page 103) Although YSA is complying with ACA training standards for employees during their first year on the job, employees are failing to meet the training requirements during subsequent years as mandated by the Decree. Not only does YSA risk the imposition of fines for non-compliance, but it also cannot be assured that OHYC employees are familiar with updated or new operational procedures. **Recommendation:** That the A/YSA take the necessary steps, to include appropriate administrative action, to ensure that all affected employees meet the training requirements as set forth in the Decree.