

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General



**Executive Summary Concerning the Results
of an Office of the Inspector General Investigation
Into Misconduct Violations by the Director of the
D.C. Department of Youth Rehabilitation Services**

2008-0425(S)

INVESTIGATIVE SYNOPSIS

The District of Columbia Office of the Inspector General (OIG) initiated an investigation in June 2008 after receiving information that on May 27, 2008, the Director of the D.C. Department of Youth Rehabilitation Services (DYRS) had taken youth offenders (residents) outside the secure perimeter of the Oak Hill Youth Center (Oak Hill) for a field trip, without following written YSA security procedures. The OIG investigation revealed that the Director engaged in conduct that violated two sections of the DPM¹ and five sections of YSA Policy Number 9.13 (set forth below) by allowing DYRS employees to transport three Oak Hill residents to his home on May 27, 2008, for a cook-out, without following proper security procedures. The OIG investigation further revealed that after one of the Oak Hill residents escaped from the Director's home, the Director permitted a substantial delay in reporting the escape to the Metropolitan Police Department (MPD).

During the investigation, OIG investigators interviewed DYRS personnel who attended the cook-out, including the Deputy Superintendent, the Superintendent, the Chief of Staff, a Supervisory Motor Vehicle Operator, two Correctional Officers, and the Director. OIG investigators also reviewed written YSA procedures for residents leaving a secure facility.

YSA procedures require DYRS personnel to adhere to the following security procedures while escorting residents from a secure facility:

- ◆ take all responsible steps to maintain physical custody of youths at all times (YSA Policy Number 9.13 § V.A.4);
- ◆ maintain visual contact with the youth at all times (*Id.* § V.A.5);

¹ DPM § 1803.1, Responsibilities of Employees, provides, in pertinent part, that District government employees shall avoid conduct, which might result in or create the appearance of: (a)(2) Giving preferential treatment to any person; and (a)(6) Affecting adversely the confidence of the public in the integrity of government.

- ◆ check the youth's restraints prior to departing in the vehicle and before getting off the vehicle at the destination; ensure compliance with all written policy regarding the use of physical restraints (*Id.* § V.A.7);
- ◆ immediately report the escape of a youth to the institution Control Center, and notify local law enforcement officials (*Id.* § V.A.10); and
- ◆ Only upon written authorization of the Superintendent, may the use of leg irons and handcuffs be reduced. A minimum of two on duty YSA Youth Correctional Officers shall escort each youth (*Id.* § V.D.2).²

The OIG investigation revealed that on May 27, 2008, DYRS employees transported three Oak Hill residents to the Director's home, located in northwest Washington, D.C., for a cook-out, and later to attend a play at the Carter Baron Amphitheatre. The Oak Hill residents were not placed in any security restraints during transport or while at the Director's home. The three Oak Hill residents were escorted by a total of two DYRS Correctional Officers and the transport van was driven by the Supervisory Motor Vehicle Operators. On the way to the Director's home, the transport van containing the three Oak Hill residents picked up two former Oak Hill residents and took them to the Director's home as well.

While at the Director's home, the three Oak Hill residents walked around unrestrained and unescorted. After one of the Oak Hill residents (Resident 1) asked the Director's wife for permission to go to the basement to look for his cellular telephone, Resident 1 went to the basement, alone and unescorted, and escaped. Resident 1 was discovered missing at approximately 6:15 pm, after DYRS personnel noticed that the basement exit door was unlocked. DYRS personnel canvassed the area for approximately 30 minutes. Then, the Superintendent and the Deputy Superintendent placed calls to Resident 1's home and continued to look for Resident 1 near his home for approximately 2 hours while the remaining DYRS personnel escorted the other two Oak Hill residents and the two former Oak Hill residents to the play at the Carter Baron Amphitheatre. DYRS personnel returned to Oak Hill with the two residents at approximately 8:45 pm, at which time, the DYRS Officer of the Day was notified of Resident 1's escape. The Officer of the Day then notified MPD of the escape. Resident 1 was apprehended when he was arrested on June 17, 2008, for commission of a narcotics offense.

In interviews with OIG investigators, both the Superintendent and the Deputy Superintendent explained that Oak Hill is a maximum security facility for youth offenders and that a court order is required to transport a resident from Oak Hill, except for medical treatment or court appearances.³ In addition, both the Superintendent and the Deputy Superintendent said that residents are required to be physically restrained with belly chain handcuffs and leg irons when transported from the facility. The Superintendent further

² As of January 23, 2009, YSA Policy Number 9.13 was superseded by YSA Policy Number 08-9.6A, which (*inter alia*) no longer requires mechanical restraints on youth transported to community programs/events. *See id.* § VII(G)(2)(d).

³ The investigation revealed no evidence that a court order had been obtained to transport Resident 1 or the other two residents from Oak Hill.

explained that DYRS policy mandated security and control during transportation, and that Oak Hill residents transported from the facility are required to be under the control of two DYRS correctional officers.

Both the Superintendent and the Deputy Superintendent told OIG investigators that the Superintendent verbally had waived the requirement that Oak Hill residents be restrained when leaving the facility. The Superintendent acknowledged to OIG investigators that he did not authorize a reduction in security procedures, in writing, as required by DYRS policy. The Superintendent told OIG investigators that he implicitly understood, from having dealt with the Director over the past 3 years, that the Director did not want the three residents restrained during transport to or while at the Director's home.

In interviews with OIG investigators, the Supervisory Motor Vehicle Operator and the two Correctional Officers confirmed that the three Oak Hill residents were transported to the Director's home without security restraints, even after they picked up two former Oak Hill residents. They also confirmed that the three Oak Hill residents were unrestrained while at the Director's home. The Deputy Superintendent told OIG investigators that Resident 1 and the other Oak Hill residents had unrestricted freedom of movement without restraints while attending the cook-out at the Director's home.

One of the Correctional Officers told OIG investigators that when it was discovered that Resident 1 had escaped from the Director's home, the Correctional Officer immediately notified the Deputy Superintendent. The Deputy Superintendent told OIG investigators that Resident 1 was discovered missing at approximately 6:15 pm. The second Correctional Officer told OIG investigators that the other DYRS personnel who were present, the Director and the Superintendent, also were notified of Resident 1's escape, but estimated that the time was approximately 7:00 pm.

The second Correctional Officer told OIG investigators that after Resident 1 was discovered missing, the group went on to the play. The Superintendent and the Deputy Superintendent called Resident 1's home and continued to look for him, all with negative results, while the rest of the group went to the play. After the group that went to the play returned to Oak Hill at approximately 8:45 pm, the second Correctional Officer wrote an Incident Report of Resident 1's escape and provided it to the Officer of the Day. The Officer of the Day confirmed to OIG investigators that he was not notified of Resident 1's escape until the two Correctional Officers had returned to Oak Hill, which was several hours after Resident 1's escape. The Officer of the Day promptly notified MPD, which was his responsibility because he was the Officer of the Day. The Superintendent acknowledged to OIG investigators that there had been a delay in notifying MPD of Resident 1's escape, in violation of DYRS policy.

The Superintendent also told OIG investigators that under the Director's administration, it had become common practice to disregard agency procedures regarding the security and control of Oak Hill residents in transport. The Deputy Superintendent told OIG investigators that during the Director's administration of DYRS, it had become standard

operating procedure to violate written DYRS policy on security and control when escorting Oak Hill residents from the facility and the lack of adequate security with Resident 1 was not an isolated incident.

During his interview with OIG investigators, the Director said that he was generally familiar with YSA Policy Number 9.13, but was not knowledgeable about the specific details. He acknowledged, however, that DYRS protocol requires residents to be handcuffed while being transported to and from Oak Hill, but said that he was opposed to residents being handcuffed and/or otherwise physically restrained when transported to events that were designed to be rehabilitative in nature. The Director also told OIG investigators that in discussions with his staff, he made it clear that he objected to placing residents in physical restraints during transport. The Director acknowledged that the Superintendent and Deputy Superintendent had informed him that residents were to be handcuffed during transport and that exceptions needed to be in writing.

With respect to the events of May 27, 2008, specifically, the Director said that Resident 1 and several other Oak Hill residents had approached him requesting to attend the Memorial Day cook-out at the Director's home.⁴ The Director intended to take those who attended the cook-out to the play at the Carter Barron Amphitheatre. Resident 1 and other residents had attended a Memorial Day cook-out at the Director's home in 2007, without incident, and he had other residents at his home on three to four occasions. The Director also told OIG investigators that although he did not recall specifically instructing the Superintendent not to restrain Resident 1 and the other residents while they were transported to his home, he was certain that the Superintendent was aware of the Director's feelings toward handcuffing residents. The Director also told OIG investigators he did not regret that Resident 1 had not been placed in physical restraints while being transported to the Director's home and he admitted that DYRS procedures had been violated.

The Director further acknowledged that none of the residents were handcuffed or otherwise restrained while in his home and that the atmosphere was too relaxed, which created the opportunity for Resident 1 to escape. According to the Director, DYRS security personnel should have maintained continual visual contact with Resident 1. The Director also accepted responsibility for Resident 1's escape. The Director told OIG investigators that after Resident 1 escaped, he instructed the Chief of Committed Services,⁵ who was attending the cook-out, to contact Resident 1's mother in an attempt to locate him, with negative results. Staff members then searched for Resident 1 for 20 to 30 minutes before proceeding to the Carter Barron Amphitheatre. Finally, the Director

⁴ One of the Correctional Officers also said that after it was discovered that Resident 1 had escaped, one of the other Oak Hill residents told him that Resident 1 planned to use the field trip to the Director's home as a means of escape.

⁵ OIG investigators interviewed the Chief of Committed Services who stated that he was not present at the Director's home for the cook-out. He said, however, that he received a telephone call from either the Director or the Chief of Staff, informing him that Resident 1 had escaped. The Chief of Committed Services told OIG investigators that he then notified Oak Hill that Resident 1 had escaped and learned that someone already had contacted Resident 1's mother.

said that when a resident escapes, DYRS must notify MPD, but at the time of his OIG interview, he did not know whether MPD had been notified of Resident 1's escape.

ANALYSIS AND CONCLUSIONS

The Director violated five sections of YSA Policy Number 9.13 by failing to require DYRS personnel to follow DYRS written security procedures when removing residents from a DYRS facility. The Director allowed his personal feelings regarding security restraints and other security procedures to create a relaxed atmosphere, which resulted in DYRS personnel failing to properly secure, restrain, and maintain visual contact with residents while they were being transported to and moving within the Director's home. In addition, the Director permitted a substantial delay in reporting the escape of Resident 1 to the MPD. The Director's actions in permitting the violation of five sections of YSA Policy Number 9.13 resulted in him giving preferential treatment to the three residents who attended the cook-out at his residence on May 27, 2008, and affected adversely the confidence of the public in the integrity of government by allowing Resident 1 to escape and placing the public's safety in jeopardy, thereby violating two sections of the DPM.

Therefore, the issue of whether the Director violated DPM §§ 1803.1 (a)(2) (Giving preferential treatment to any person) and (a)(6) (Affecting adversely the confidence of the public in the integrity of government) is **SUBSTANTIATED**.

The issue of whether the Director violated five sections of YSA Policy Number 9.13 (Security and Control, Escorted Trips) is **SUBSTANTIATED**.

RECOMMENDATIONS

Based on the results of this investigation, the OIG recommends that the City Administrator:

- Address the conduct of the Director in an appropriate manner; and
- Address with DYRS personnel the need to follow appropriate security procedures at all times to ensure the safety of those entrusted to the care of DYRS and members of the public.

January 28, 2010