California
Department of Corrections and Rehabilitation

DeWitt Nelson Youth Correctional Facility

STAFF SAFETY EVALUATION

August 3 – 18, 2005

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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 August 3-18, 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 facilities located in the Northern California Youth Correctional Center (NCYCC) complex. Four separate youth facilities are located within the NCYCC including the DeWitt Nelson Youth Correctional Facility (DWNYCF), the O.H. Close Youth Correctional Facility (OHCYCF), and the N.A. Chaderjian Youth Correctional Facility (NACYCF). The Karl Holton Youth Correctional Facility (KHYCF) is the fourth facility but it is currently not being utilized. Each facility was reviewed individually and the results documented in separate reports.

The evaluation protocol consisted of a request for advance data on staff assaults from each facility 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, staff training and safety equipment.

EVALUATION METHODOLOGY

An entrance letter was sent to the DWNYCF Assistant Superintendent, Jeff Harada, informing him of the August 3-18, 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 for staff assault or attempted assaults (SIR) 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. (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 August 3, 2005, at the NCYCC, with a joint entrance conference with that was attended by each facility's superintendents, appropriate institutional administrative staff and evaluation team members. The conference included an operational overview of the

institution by Assistant Superintendent Harada as well as an overview of the evaluation process by CSA Field Representative Bob Takeshta.

Using the ward visiting room at DWNYCF 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 (Attachment D). The responses were categorized and a summary of the responses is included in the Staff Interview section of this report (pages 26-29). 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.

A joint exit conference was conducted on August 18, 2005 with Eric Umeda, Acting Superintendent NACYCF; Steve Gardner, Major NACYCF; Heyman Matlock, Assistant Superintendent, OHCYCF; Anthony Lucero, Treatment Team Supervisor OHCYCF; Jeff Harada, Assistant Superintendent, DWNYCF; Michael Minor, Chief of Security, DWNYCF; Bernard Warner, Chief Deputy Secretary of the Division of Juvenile Justice (DJJ); Yvette Marc-Aurele, Deputy Director of Institutions and Camps Division of the DJJ; Elizabeth Siggins, CDCR Juvenile Policy and Sharie Wise, CDCR. The exit conference included a presentation of the team's findings and observations as well as a summary of comments made by staff.

FACILITY PROFILE

DeWitt Nelson Youth Correction Facility (DWNYCF) is located within the Northern California Youth Correction Center Complex (NCYCC) in Stockton, California. The Center includes three other youth correctional facilities, each being utilized to provide services to a selected ward population. The Youth Authority Training Center is located next door to and outside of the secure perimeter of the NCYCC.

DWNYCF was initially opened in 1971 as a youth forestry fire camp and youth training facility. Wards were provided necessary fire suppression training as well as educational and vocational classes. The fire camp operation was discontinued in 1990 but the vocational training continued with as many as 220 wards leaving the facility each day to participate in work in various trade programs. Some of wards remained within the NCYCC complex but many were allowed to leave the complex, either under supervision by staff or as part of a work furlough program pending release, to participate in trade programs or provide community service.

Current Usage

The ward population at DWNYCF is now limited to males over the age of 18 years. With the closure of the Northern Youth Correctional Reception Center and Clinic (NYCRCC) in Sacramento in 2004, DWNYCF became the Northern California reception center for youth parole violators over 18 years old. The facility remains as an academic and vocational education institution providing programs to as many as 185 wards attending classes each period. Following an escape from an outside work crew in December 2004, the number of wards participating in work programs outside of the facility has been curtailed. Now only about 30 wards are assigned to work programs outside of the facility, and they must remain within the secure perimeter of the NCYCC. Work crews are no longer provided for community service projects outside the complex.

This facility utilizes an “Open” program to achieve the Agency’s overall mission of providing a “Normative Culture” program to wards. The intent is 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.

While the living units at this facility are not segregated by gang affiliation or by race, careful attention is given to ensure no single group is allowed to be together in sufficient numbers to exert control over others. The effort even continues during times of food service when wards are monitored to ensure that “rainbow” seating (the integration of all groups) is achieved.

The living units are individual buildings with dormitory configurations, separated by large areas of grass. Each building has one wet room which is not considered a sleeping room and is limited to short term use. The facility has no capability to provide "close" security living or administrative segregation housing. Crowding was not an issue at this facility.

DWNYCF offers three specialized programs:

- Short Term Substance Abuse Program (STSAP) is a 120-day drug treatment program.

- Substance Abuse Treatment Program (SATP) is a 6-month drug treatment program.

- Specialized Counseling Program (SCP) deals with sex offenders and other wards with severe emotional problems.

Population Summary

The design capacity at DWNYCF for all housing units is 400 including Angeles Hall, a living unit that was removed from service following a disturbance in February of this year. On the first day of our evaluation, the facility housed 419 wards. The wards' ages ranged from 18 to 24 and the average age was 20 years old. Over 100 wards, 25% of the facility's population was over the age of 21. Fifty-eight wards have reentered the system as parole violators.

The majority of wards have histories that include documented gang affiliations. Management staff informed us that many of the wards are older and have distanced themselves from the youth gang mainstream; however, many wards remain defiant, argumentative and challenging to authority.

- A large percentage of wards have histories of substance abuse. Two programs for substance abuse are offered at DWNYCF and about 110 wards are enrolled.

- Approximately twenty-five percent of the ward population has been committed for crimes involving sexual assault. Sixty-two wards are enrolled in the ISCP program.

- Forty-eight percent of ward population was Hispanic, twenty-nine percent black, fifteen percent white and eight percent were classified as "other".

Staffing Allocation and Availability

The management ranks at DWNYCF include the following classifications: Assistant Superintendent, Major, Captain, Treatment Team Supervisor and Parole Agent III. The funded staffing allocation for all custody personnel is 158, including the management staff, Lieutenants, Sergeants, Senior Youth Correctional Counselors, Youth Correctional Counselors, Youth Correctional Officers, Parole Agents and Medical Technical Assistants (MTA). DWNYCF has 4 vacant custody positions and 6 custody personnel are off work or otherwise unavailable for assignment. Thirty-four permanent/intermittent employees are available for shift coverage. Of the 256.5 non-custody position allocations, there are currently 59 vacancies and 6 non-custody employees were off on long-term leave (over 3 months).

Medical services are provided at a central location for all facilities within the NCYCC complex. The Outpatient Housing Unit (OHU) is staffed with 33 medical personnel. Mental Health Services are also provided by a staff of nine. Twelve MTAs are assigned to the OHU.

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	158	4	6	148
Non-Custody Staff	256.5	46	6	204.5
Total	414.5	51	12	364

PHYSICAL PLANT

DWNYCF is one of four youth correctional facilities located within the secure perimeter of the NCYCC. DWNYCF has its own secure perimeter fence enclosing many buildings such as the eight living units, a receiving unit, administrative offices, educational buildings, vocational shops, gymnasium, and a dining hall. The Assistant Superintendent of DWNYCF also oversees the central plant area of NCYCC that includes an Outpatient Housing or medical unit (OHU), medical transportation unit, kitchen, entrance/guard gate, staff training office and plant operations (maintenance shops).

Seven of the housing units are currently in operation as living areas for wards. The housing units are separate buildings and are generally aligned around the perimeter of the exercise field. All living units are open dormitories (see Attachment C for design and current capacities).

Educational services are provided onsite within the secure perimeter. There are twenty classrooms. Some of these classrooms are vocational education programs. Some of the vocational programs available to the wards include landscaping, graphics arts, welding, woodshop, and computer labs.

Each of the living units have similar design configurations. An officer's station is centrally located within each living unit. Three dormitories, a shower/restroom area and a dayroom are located around the control room. A combination of single, double and triple bunks comprise the bed configurations within each dormitory. One single-occupancy sleeping room is provided on each living unit. This sleeping room contains a poured in place concrete bunk and a combination wash basin/toilet unit and a camera that is monitored from within the officer's station. Additionally, office space and storage rooms are provided in each living unit.

Each unit has one staff assigned to the first watch, two staff on the second watch and three staff on the third watch. An additional staff is assigned to overlap the second and third watches. The Lassen living unit has an enhanced staffing level due to the type of program provided.

The Lassen Dorm contains the 120-day drug program (STSAP). This program targets older wards returning to custody due to parole violations with identified substance abuse problems. Several group-counseling sessions are held throughout the day, and acceptance in the program is limited to wards with a high school diploma GED. The daily group counseling sessions conflict with the educational program schedule, preventing co-enrollment.

The Modoc Dorm contains a six-month drug program (SATP). Wards participating in this program regularly attend school.

The Tahoe Dorm provides housing for the wards that have work assignments. These assignments include forms clerk, public service, janitorial, central warehouse, grounds crew, landscaping, painting, canteen, kitchen and laundry work within the DWNYCF and within the NCYCC complex.

The evaluation team toured the institution, reviewed institutional procedures and interviewed staff at various classification levels. 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: The lack of maintenance for the entire complex contributes to an unsafe environment.

Discussion: The lack of maintenance is apparent immediately upon entering the front gate of the complex. Overflowing trash cans, lawn areas that were brown, flowerbeds overgrown with weeds, and fields of heavy plant growth were observed driving through the complex to the facility. These same issues were observed within the facility. The following facility maintenance issues were observed throughout this facility:

ELECTRICAL

- Numerous perimeter fence lights are burned out/not working.
- Numerous interior lights are burned out/not working.
- The electrical supply is not sufficient for the demands of current equipment. This was particularly evident in the school area where only half of the computers and copiers could be turned on at one time without tripping the breaker.

PLUMBING

- Standing water was observed on the floors due to leaking pipes.
- Standing water and large puddles of mud were observed throughout the facility grounds created by leaking irrigation water lines.
- Team members observed many washbasins and showers that cannot be turned off and continually run.
- Exterior hose bibs continuously leak and create standing puddles.
- Numerous showers, toilets, and washbasins within each living unit were observed out of order.
- Each living unit has broken or missing urinals. Plant Operations reports these fixtures are antiquated and that replacement parts are no longer available. Furthermore, the standardized plumbing application utilized by modern urinals will not match up to the antiquated drain/water supply provided. As a result, modern urinals cannot be used as a replacement.

STRUCTURAL

- Window and doorframes are severely rusted in the shower/bathroom area. In some cases, the frames are no longer able to hold the glass, or allow for pieces of metal to be pried away and used as a weapon.
- There is significant structural damage to walls in the shower areas due to leaky or broken water pipes and fixtures.

- Large holes were observed in the interior walls on several units, as well as peeling paint.

VERMIN/VECTOR CONTROL

- Several evaluation team members observed ants and roaches and rodent droppings in the food preparation areas of the facility kitchen and in the central food service kitchen.
- Large populations of ground squirrels inhabit the complex and facility. The burrows create a significant safety issue for staff responding to emergencies and to the wards utilizing the outdoor recreation areas. Plant Operations personnel report the three large water storage tanks that supply water to the entire complex are in jeopardy due to the squirrels burrowing underneath them.
- Skunks inhabit the complex and facility. Evaluation team members observed skunks on the grounds. Supervisory staff reported occasions where staff were recently sprayed by skunks and sent home.

HVAC

- The living units utilize swamp coolers. Staff reports that these coolers provide minimal cooling during the summer months and that temperatures within the living units typically exceed eighty-five degrees.

FENCING

- The sliding gate at the entrance to the NCYCC complex is damaged and will not close. This gate is part of the primary fence that surrounds the complex.
- The bottom edge of the perimeter fence is not set in concrete. As a result, there are several areas where animals have burrowed under and created spaces for unauthorized entrance or egress.

CENTRAL KITCHEN

- Walk-in refrigerators, freezers and chillers have deteriorated to the point that some units cannot keep up and over heat. In some instances this is due to large holes that allow outside air to exchange with the cool air. In an effort to cool one of these refrigeration units, a garden hose with a sprinkler head continuously applies water to the unit. The water flows onto the unit and across a walkway, which is used daily by office staff. Algae have formed on the sidewalk forming a slip hazard. Standing water provides a breeding area for mosquitoes and mud is a constant problem as well.

EMERGENCY POWER

- Central plant operations for the complex utilizes LP gas to fuel the central boiler that supplies steam, hot water, and heat to central operations buildings within the complex. Additionally, LP gas is the fuel source for the emergency power generators that operate the domestic water supply delivery pumps and effluent pumps for the complex. In the event that the supply of LP gas were lost, a large propane tank is located on site that serves as a

back up fuel supply. A conversion station is utilized to convert the propane gas into a compatible fuel for the generators. Plant Operation staff report this conversion station is in disrepair and the manufacturer will not supply parts for the conversion station due to its age and disrepair.

Providing proper levels of building maintenance is as important to the overall safe operation of a secure detention facility as is providing sufficient staffing levels. A seemingly harmless lose or broken bolt can become a potentially harmful weapon. The affects from many years of neglect endured by this facility were observed in every building trade. In many instances, it is obvious that the solution to some maintenance issues has elevated from a simple repair to costly replacement.

Plant Operations staff reports that the maintenance staffing level is inadequate. Currently, there are 44.5 maintenance personnel assigned to the complex and only 36 of those positions are filled. Preventive maintenance does not occur at this facility or at any of the facilities within the complex. Maintenance occurs only on an emergency basis and the emergencies are prioritized daily. Due to the constant crisis mode, Plant Operations was unable to provide documentation regarding the number of work orders finished.

Finding: The work order tracking system currently utilized by Plant Operations and the facility is ineffective.

Discussion: Evaluation team members were unable to determine which work orders were addressed and which ones were still outstanding. Evaluation team members observed frustration with the tracking system by both Plant Operation staff and facility staff. The ineffective tracking system combined with a lack of communication between Plant Operation staff and facility staff combines to exacerbate the frustration level. The evaluation team recommends regular meetings between Plant Operations staff and facility staff to discuss and prioritize maintenance issues. Additionally, reexamination of the current work order tracking system is needed to ensure requests for work are addressed to the satisfaction of Plant Operations and facility staff.

Finding: There was heavy plant growth between the perimeter fences that could conceal contraband or aid in escapes. In some areas, the heavy plant growth is a fire hazard.

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.

Staffing

Finding: Direct supervision of security staff is not being adequately accomplished.

Discussion: Currently there is not an assigned security and escort supervisor or recreation field area supervisor dedicated to the sole supervision of security staff assigned to the housing units or to the facility's large recreation yard. Instead, YCOs assigned to these areas are supervised by security supervisory staff who are assigned other duties and posts that require their constant presence. The evaluation team recommends assigning a facility Sergeant on both 2nd and 3rd

watches dedicated to supervise the work of the YCOs assigned to the units and security and escort.

Finding: At times, there are too few security and escort staff to safely respond to emergencies within the facility.

Discussion: There are only two security and escort staff assigned to each watch. At times, multiple alarms occur simultaneously within the facility. An additional security and escort staff should be assigned to each watch.

Finding: Current staffing patterns do not allow for the Senior Youth Correctional Counselors (SYCC) to adequately supervise the YCCs assigned to each hall housing wards

Discussion: There are frequently times when there is not an SYCC assigned to a unit to oversee the staff working in the unit. Also, when SYCCs are present, they are assigned to a posted position and cannot leave their assigned hall to provide supervisory oversight in the sister hall of the unit. The evaluation team recommends assigning an SYCC (that does not have post assignment responsibilities) to each unit on the 2nd and 3rd watches. This would allow for more effective supervision of YCCs and of the program delivery.

Finding: Staffing levels among teaching staff may be an underlying cause for concern for staff safety.

Discussion: DWNYCF has 59 vacancies among the allotted 256.5 non-custody positions (includes food services, business services, plant operations, education, personnel, medical and mental health personnel). Of particular concern, 8 of the 35 educational staff positions are vacant. The team was told teachers are not replaced when they are absent from work and classes are cancelled. When wards are not in the classroom, they remain in the living units where custody staff is at a minimum (typically two staff until 1200 as opposed to three and four staff on third watch) and no substitute activity is available. The evaluation team observed several wards not attending school during school hours.

Supervising these wards creates a safety issue for the housing staff during this time. The team recommends either increasing the staffing in each living unit 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: Staffing levels among maintenance staff may be an underlying cause for concern for staff safety.

Discussion: There are 12 vacancies in plant operations, the unit responsible for maintenance at all of the facilities located within the NCYCC complex. Lack of maintenance has been a frequent complaint during our interviews with staff and the review team has personally observed many examples of overdue deferred maintenance. Budget restrictions may have contributed to cutbacks on preventative maintenance but in any event, trained professionals are needed to make the necessary repairs.

Finding: The staff use of vehicles to monitor ward escort/movement and some "patrol" functions is ineffective.

Discussion: Rather than walk with the wards, security staff supervise the movement of large groups by following in a vehicle. Security staff also use vehicle to respond to emergency calls within the facility.

Consideration should be given to eliminating the use of staff patrol units to escort wards during ward movements. Staff presence in a vehicle during ward movement ensures the wards report to the proper areas, but it does not provide interaction or direct supervision of the movement. Staff assigned to the vehicle cannot hear the conversations of the wards. Staff posted in vehicles are ineffective in quelling disturbances. The elimination of the vehicle escorts and posting of staff on foot as escorts would greatly enhance the escort process. This would allow the staff to communicate with the population, gather intelligence, and identify the victims and assailants should an incident occur during ward movement.

Additionally, security staff assigned to the large movement yard should be assigned specific duties to patrol and monitor the units during movement and non-movement periods. These staff could tour the living units, provide individual escorts, random searches of common areas, ward cells/rooms and wards themselves. Each position could be responsible for specific housing units and should remain visible at all times. With specific responsibility for assigned units, security staff could be in a better position to respond to emergencies, or assist unit staff should the need arise.

Finding: Current staffing levels have resulted in mandated overtime for custody staff.

Discussion: Volunteers and intermittent employees are usually available to work overtime to provide vacation, training, and sick leave coverage. An average of 26 correctional officers/counselors per month have been ordered to work a double shift since January 1, 2005. Managers explained that the need for overtime backfill stemmed from heightened sick leave usage. Typically, an average of 60 shifts must be covered each week at DWNYCF. During May, June and July of 2005 the records reflect as many as 21 custody personnel have been ill on the weekends.

When shifts cannot be filled with volunteer overtime or part-time intermittent employees, staff must be "inversed" or order over. The replacement staff person may not be familiar with the assignment's post orders, daily program or be aware of any other staff safety issues. When staff are working double shifts there is an increased opportunity for staff injuries, worker compensation claims, sick leave usage and a negative effect on employee morale.

Procedures

Finding: The DJJ 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, we were told that the agency had no central classification system. An in depth and detailed assessment of each ward is performed at intake into the system but the information is not readily available to staff members dealing with the ward in the living units. Currently the DJJ Headquarters decides placement based on age and program needs. At the facility level, 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 also determined at Juvenile Justice Headquarters and in consultation with mental health services 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.

Local adult and juvenile detention facilities and the Adult Operations Division of CDCR utilize a means of identifying those in their care who 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. A formal classification system is planned for the youth correctional system but it 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.

The team recommends that the Juvenile Justice Division continue to develop a system for identifying and reviewing the security needs of each ward in custody and identify specific housing and programming based on those 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.

Finding: Staff reported that emergency fire evacuation drills are not being conducted.

Discussion: The First watch staff have indicated they do not conduct any simulated Fire Drills. The second and third watch staff indicated that the emergency fire evacuation drills are not consistently conducted. Specifically staff reported that to the best of their memory, these drills have not been conducted within the last two years. Additionally there was no documentation within the living units or control center that evacuation drills have been conducted. Emergency

fire evacuation drills are necessary to ensure the safety of the staff working at this facility as well as the wards in their care.

Finding: There is no accountability for tools maintained in the units.

Discussion: Staff reported that barber boxes containing scissors and other barber tools, as well as brooms and mops are not being inventoried. Methods are needed to accurately inventory tools and equipment to which wards have access.

Finding: The Institutional Policy Manuals 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. 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 these indicators in a Forward acknowledgement, it is difficult for staff to determine if these procedures are outdated, current, or reflect procedural changes to the emergency operational plans. 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 vague, not referenced and included in the Multi-Hazard Emergency Plan. No documentation of practice drills was available for review.

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 Log 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.

Policy section 2150, the portion covering escape procedures, has not been reviewed or updated since January 2002. Two wards, one in custody for murder, escaped from an outside work crew in December 2004. The outside work programs have since been cancelled and an expected review of this policy was never performed. It is our understanding a revision of this section is pending approval.

Finding: Post orders located within each living unit were generic and outdated. They did not reflect current practice.

Discussion: Of particular concern were post order related to emergency response duties for the staff posted within the hall. 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: Staff were unable to produce current policy and procedures regarding emergency procedures, deployment of chemical agents, or daily operations procedures.

Discussion: Staff relied on memos issued by the facility management for direction on many of these policy maters and developed their own procedures for implementation. Secure detention facilities must have clear policy and procedures that dictate the daily operations of the institution.

Finding: Post orders for the YCC and YCOs do not contain the signature of authority or date of revision. There is no process in place (in the units) to ensure staff has read and understand the requirements of the post orders (post order acknowledgement).

Discussion: Updated post orders are essential for the safe operation of detention facilities. The high number of staff working on units in which they are not normally assigned or familiar, exacerbates this situation.

Finding: Staff indicated that individuals are assigned to the emergency response teams as they report to work. The unit post orders did not delineate responsibility for emergency response. In addition unit staff were uncertain as to who would respond to incidents or emergency situations and what security equipment to take.

Discussion: Updated post orders and procedures requiring staff to read and understand post orders are essential for the safe operation of detention facilities.

Finding: No documentation was present to support that area searches are being conducted.

Discussion: Documentation was not present requiring the searching of school classrooms, maintenance areas, common grounds, vocational education areas etc. Although some searches were being conducted, there was no documentation indicating that a search had taken place; what, if anything was found; and what was done with any contraband discovered. Procedures for ongoing random area searches and documentation of those searches are essential components of maintaining a safe institution.

Finding: The Chaplain was unaware of duty statements that would provide guidance to the religious staff working in the chapel. The chapel area did not contain areas clearly marked as out of bounds.

Discussion: 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.

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 the Risk 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.
- Summary of the annual Safety and Security review (1800 Report).

Staff Assault Incident Reports

Finding: Insufficient data was available to identify obvious trends relative to the issue of staff assaults.

Discussion: After a collective review and discussion of the above listed documents, there were a few notable statistics and no issues were identified as being significantly consistent among the various incidents.

Five incidents of battery on staff were reported during the 2004-2005 fiscal year at the DeWitt Nelson Youth Correctional Facility.

- The victims included Senior and Youth Correctional Counselors and Youth Correctional Officers. No medical staff or non-custody staff were involved.
- The victims included 4 males and 1 female.

- The race of the victims included:
  - 3 white.
  - 1 black.
  - 1 hispanic.

- The average age of the victims was 39.

- Four of the victims had over 10 years of experience with the department and one had 2 years. One of the victims had worked at the facility less than 2 months while the others had been at the facility for 2 or more years.

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

Discussion: No significant variance was noted when comparing the race, age or gang affiliation of the assaultive wards to that of the overall ward population. Hispanic wards were involved in 3 incidents, white wards in 1 and Asian wards were involved in 1, a ratio not inconsistent with the facility population.

The average age of wards involved was 20, the same as the facility population's average age. Three of the wards involved in the incidents have documented gang affiliations. Four of the wards had been at DWNYCF less than 3 months and the fifth had been there less than 9 months.

Finding: Hours of the day and days of the week may be factors in assaults on staff.

Discussion: The frequency of incidents was highest during the third watch with 3 occurrences while none occurred during first watch. Three incidents occurred within an 8-day period in January; however after careful review they were determined to not be related. The remaining 2 were 10 months apart. All of the incidents occurred on a Thursday, Friday or Saturday.

Finding: Insufficient data existed to identify any relationship between the wards involved in assaultive behavior and their program involvement.

Discussion: Four incidents involved wards on general program status and one incident involved a ward participating in a drug program.

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

Discussion: No ward-manufactured weapons were utilized in the incidents reviewed. None of the assaults involved gassing. In one of the incidents, a milk carton was used thrown at the staff person. In four of the cases reviewed, wards used their hands to batter or attempt to batter staff.

Finding: Statistics provided by the safety officer support the need for increased training in areas including 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

Discussion: In the Serious Incident Reports reviewed from fiscal year 2004-2005, 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 that three victims were off duty as a result of the assault and one victim remains off duty following a January incident.

Finding: The safety officer has made significant efforts to promote safety among the staff. Only 2 injuries were reported as a result of responding to emergency incidents.

Discussion: The safety officer holds regular safety meetings and includes the appropriate persons. Recent injuries are discussed. Action plans are developed and reviewed at subsequent meetings. The safety officer writes and distributes a monthly safety newsletter by e-mail to all staff discussing relevant safety topics. Within 2 months of any type of an injury, the relevant topic information is included in the newsletter and shared with other safety officers at the NCYCC complex.

Finding: Providing computer network and e-mail access to all staff members promotes the delivery of safety information.

Discussion: The safety officer sends out an e-mail every 2 weeks and includes safety information. All safety training material, including handouts, bulletins and training curriculum is available to all staff via a network server. All Material Safety Data Sheet safety information on hazardous materials is also included. The integrity of the information is protected because all the documents are presented in "read-only" Adobe PDF format.

Training

Finding: Custody staff appear to be receiving training in safety related issues, but mandated annual training classes and 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 update training. The policies identified a baseline of training topics to be included. Institutional-specific training is added to the baseline to achieve a total of 52 hours of required training.

The documentation concerning the delivery of mandated annual update training for both custody and non-custody staff is provided to a central training officer for NCYCC. The training hours listed in the documentation reviewed was not in compliance with policy. Custody staff at DWNYCF was provided 27 hours of annual training during the last fiscal year, July 2004 through June 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
- Fire Safety, 1 hour
- Safety and Emergency, 1 hour

- Sexual Harassment, 1 hour
- CPR, 4 hours
- Inappropriate relationships, 1 hour
- Infectious disease, 2 hours
- Respirator protection, 3 hours
- Use of force, 2 hours
- Effective interaction, 2 hours
- Signs of mental illness, 1 hour
- Suicide prevention, 1 hour
- Staff accountability, 1 hour
- Workplace violence, 2 hours
- Code of Silence, 1 hour
- Department reorganization, 1 hour
- Education, 1 hour

Finding: Perishable skills training specific to armed assignments has not been documented.

Discussion: Custody staff in specific assignments (those requiring the use of weapons), such as transportation or tactical team require additional training to maintain perishable skills. For example, the Institutional and Camps policy manual specifies that designated armed staff are to receive 4 hours of annual training for use of baton. We were unable to locate documentation that ongoing baton training is being provided. The firearms training requirements are being satisfied.

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. A dedicated training manager may ensure all staff receive the appropriate training.

Discussion: The one hour training on Code of Silence was the only class that appeared to have been attended by all staff. CPR was also well attended; however, only 167 out of 180 officers, 52 education staff and 25 support staff were scheduled to attend. The overall attendance rate at training appeared to be about 76 percent among the officers scheduled to attend. Training records only track hours, not which classes were actually attended. While the team was told make up classes are offered and staff needing to attend are scheduled, the records do not reflect that follow up is done to ensure absentees actually attend the "make-up" classes. Not all officers were scheduled to attend 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. 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.

The training manager had several duties other than training. His primary duties included overseeing the Disciplinary Decision Making System (DDMS)/Ward Grievance Program, DNA Collection and acting as the facility criminal investigator/court liaison.

Finding: The Supervisors are not receiving annual refresher training necessary for their positions including effective supervision, leadership, discipline and contract agreements.

Discussion: After discussions with staff and upon review of the training records, it appears that any supplemental training or update training regarding supervision issues is dependent on the interest level of the facility management. No formal training plan was provided to the facilities to provide direction regarding supplemental supervision training. Instead, it is up to the facility management to decide appropriate and necessary training.

Finding: Training records do not reflect that Youth Correctional Counselors are receiving training updates specific to ward counseling and supervision.

Discussion: In the training records reviewed, the team was unable to identify annual training specific to the subject of ward counseling. The Institutional and Camps policy manual specifies that all YCC and YCO staff are to receive 16 hours of annual training.

Finding: A minimum of 16 hours of institutional orientation is mandated for all new staff before assuming ward supervisory duties. The training is being done for the custody staff. It was unknown if the orientation was being done for non-custody and medical staff.

Discussion: A checklist is used to document the orientation training and is maintained in the employee's personnel file. The checklist is in reality a reminder to the person providing the orientation of some of the topics to include in the orientation. It is not detailed nor is it facility specific. No review of the orientation is performed by a supervisor. The documentation information is not shared with the training division as a part of the training record.

Finding: No special training is provided to staff members specific to officer safety in combative/assaultive situations.

Discussion: A 2-hour update regarding use of force is limited to the policy intent. Actual application techniques are not included. A review of the training documentation revealed no annual update classes regarding control holds, restraint application, defensive tactics, weapon take-aways, weaponless defense, and chemical agents.

Finding: No special training is provided to staff members who act as training officers for purposes of orientation training.

Discussion: Supervisors and managers interviewed said the orientation training officers are selected based on the manager's personal assessment of the staff selected to provide the orientation. No formal process is used to recruit and select trainers. No special training is provided to staff members who act as training officers for purposes of orientation training.

Finding: No formal training program is in place to provide "field training" to newly appointed officers.

Discussion: The team asked if a "field training" program was in place to train new recruits (custody staff). Supervisors and managers interviewed said the orientation provided to new employees is limited to a 16-hour orientation process. No specialized training officers are utilized for the training/orientation.

All deputy sheriffs, police officers and the majority of local juvenile and adult correctional officers are required to complete a formal training program under the direction of a specially selected and trained officer. The program is designed to ensure the trainee is exposed to most situations that would be routinely encountered during the assignment and instructed on the expected performance. The field training program ensures the employee performs within the applicable law, the department's policy and in a safe manner. The training officer observes the employee's performance at regular intervals, documents the progress, and provides any necessary remedial instruction. The trainee must demonstrate competence before being allowed to function alone in the position. The team suggests the DJJ consider developing a formalized institutional training program for new recruits and an abbreviated program for newly transferred officers.

Finding: An annual training plan needs to be developed for the facility in concert with an agency-wide annual training plan. Both training and facility managers need to be kept current on issues involving development and implementation of the plan.

Discussion: 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 reactionary to a change in policy, practice or the law. Such frequent changes make long-term planning difficult. The team was provided a copy of the Agency's annual training plan by the facility Captain. He understood it was in effect and was concerned it was not being followed. It was his understanding that the classes included in the plan were mandated and that overtime would have to be used to ensure all staff were able to attend.

Finding: Training deficiencies at DWNYCF could be improved through better coordination and by forming partnerships to maximize the use of all available training resources.

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 training hours for the IIPP program are tracked through the NCYCC training coordinator, but the time is not credited toward the 52-hour minimum annual update. The team thought, depending on the subject matter, IIPP training might serve to satisfy both requirements if the programs were coordinated.

The Training Manager and the team suggested combining training resources with other facilities within the NCYCC complex and the Galt Training Center, to provide some of the training.

The team suggested coordinating and sharing training resources with other neighboring law enforcement/corrections agencies. For example, materials and trainers could be shared among the other facilities that exist within the NCYCC complex (NACYCF, and OHCYCF). The Juvenile Justice Training Center, located next door to the NCYCC complex and the Adult Training Center, located in nearby Galt, also have many resources available.

Following the recent reorganization, partnerships could be entered into with adult prisons to provide some of the training. Training materials would be delivered in a consistent manner to all staff. Duplication of materials and resources would be reduced resulting in significant savings. Mule Creek State Prison and Deuel Vocational Institute are located near the NCYCC complex. For example, 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 other facilities, or could be adapted to each; a partnership may result in more consistent and relevant training to all staff.

Partnerships with neighboring law enforcement/corrections agencies including state prisons, a sheriff's department or the local district attorney, might present opportunities to provide additional training to staff to improve investigative techniques. The training might include interview techniques, evidence collection and preservation, and other issues related to the successful prosecution of offenses committed within the facility.

Safety Equipment

Finding: The personal alarm systems used by staff are undependable.

Discussion: Staff reported there are several dead spots throughout the living units that do not allow reception of the signal when activated. Evaluation team members observed several alarm tests where staff demonstrated these dead spots. The FM alarms do not provide coverage within the classrooms and a separate Unisec alarm system is utilized. Teaching and facility staff reports this alarm system is unreliable as well. If an article of clothing is covering a portion of the device, the signal will be blocked when activated. Additionally, there are dead spots throughout the school portion of the facility. Facility and teaching staff that were aware of the shortcomings of these alarm systems stated they felt reasonably comfortable with the personal alarm system, however, those that are unaware of these shortcomings are placed in an unsafe situation. Management staff reports that a new personal alarm system is in the installation process, however, this process is in its second year and no completion date has been provided.

Finding: Staff reports there are not enough personal radios for all staff and that the batteries in the personal radios assigned to them do not hold a charge. Furthermore, the staff does not have the capability of charging the batteries on the unit and must request another battery from central control. Staff reported that at times, four to five battery changes are needed per shift.

Discussion: Personal radios are the means by which staff communicates with each other. Sufficient numbers of radios with dependable battery supplies are necessary for the safe operation of the facility.

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/Mace spray and latex gloves. Respirators are available in all living units and located in security vehicles. 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: Staff is assigned Oleoresin Capsicum (OC) spray canisters. These canisters are not checked regularly and there is no procedure in place to ensure the canisters are operable.

Discussion: Staff report that they check OC canisters with the armory sergeant when the think the canister is near empty. Procedures are needed to ensure the Oleoresin Capsicum (OC) spray canisters are regularly checked to ensure they are operable.

Finding: The proximity of wards to the armory and the security of the cabinetry containing the munitions creates an unsafe condition.

Discussion: The DeWitt Nelson Youth Correctional Facility (DWNYCF) munitions, less lethal weapons and equipment are maintained in the central armory. A supply of chemical agents and emergency equipment is maintained in the staff entrance control center which is staffed 24/7. An emergency supply of equipment is located in wooden cabinets directly below the staff mailboxes. The cabinets are secured with a standard desk type of locking device. During the inspection of this area the review team observed a ward sorting mail into the staff mailboxes, which are in the immediate location of the emergency chemicals and equipment. The staff control center is located in the same immediate area with no barrier, which would prevent their position being breached. A form generated by the institution is currently utilized to inventory the emergency ready bags stored at the DWNYCF entrance building.

This equipment should be relocated to an area that wards do not have ready access to is recommended. Thought should be given to assigning a staff solely responsible for the duties associated with the armory. Additionally, post orders are needed that clearly define processes for the inventory, maintenance and inspection of armory related equipment.

Finding: Stab vests have been issued to the members of the tactical team.

Discussion: Only the officers assigned to the tactical team are issued soft body armor stab resistant vests. This group of officers comprises the specialized unit mobilized for emergency incidents within the facility. The vests are assigned according to general size and are not fitted to the individual officer. A supply of vests is stored in Central Control for visitors or shift

replacement staff to wear. The vests are not assigned permanently to individual officers and must be relinquished when the officer changes assignment.

Finding: Some vests will need to be replaced and a replacement program has not been instituted.

Discussion: A review of the inventory revealed 29 vests labeled with manufacturing dates of March 1996 and February 1997 making them over 8 years old. These are older "turtle shell" vests and are not currently being used. The inventory of vests that are being used will soon reach the end of their serviceable life. Perspiration and cleaning materials can weaken the materials and reduce the effectiveness of the protective vests. Management at the facility was not aware of any program designed to replace the vests when the life expectancy has expired.

STAFF INTERVIEWS

Interview Process

The Staff Safety Evaluation Team conducted random interviews with custody staff, treatment staff, and non-custody staff at the DeWitt-Nelson Youth Correctional Facility (DWNYCF) from Wednesday, August 3 through Friday, August 5. 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 the Attachment D.

The Staff Safety Evaluation Team conducted random interviews with DWNYCF staff, on the first, second, and third watches at the following dorms: Lassen, Modoc, Sierra, Klamath, Plumas, Tahoe, and Yosemite. Staff was also interviewed at administration/control and the education center. Custody staff classifications interviewed included: assistant superintendent, the major, captain, parole agent III, lieutenants, sergeants, and correctional officers. The Intensive Treatment Program included: treatment team supervisors, parole agent I, senior youth correctional counselors, and youth correctional counselors. Non-custody staff was interviewed, and their responses are included in the section under Central Services.

For purposes of this report, the interview team is highlighting 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 Managers

The interview team met with the assistant superintendent, major, captain, and the Parole Agent III on August 3, 2005. The managers said that three staff injuries occurred in January 2005. Prior to these incidents, there had been one staff assault in the preceding year. The group agreed that DeWitt Nelson is a fairly safe facility, however they said that line staff would probably disagree with their assessment. They said two of their biggest challenges are to remind line staff not to get complacent with the wards and to be diligent in performing their duties.

They said another significant issue that managers are prohibited from questioning staff about sick leave abuse due to the last Memorandum of Agreement (MOA) negotiated by Bargaining Unit 6. Prior to this negotiated MOA, if a manager documented a pattern of sick leave abuse or extraordinary use by an employee, the manager could inform the employee that a doctor's note was necessary to explain his/her absence. Managers could go one step further by documenting this sick leave abuse in the employees' annual performance evaluations. The managers said that the current MOA prohibits them from mentioning this issue in employee performance reports or in memorandums. The managers believe that this is the cause for the increase in sick leave usage.

Finding: Low morale has increased the use of sick leave by line staff, which results in staff being held over to cover vacant shifts.

Discussion: The group said that line staff is currently working voluntary overtime on a daily basis due to staff vacancies. Because staff is working so many extra hours, it appears that they are calling in sick in order to have a day off. With the increase in sick leave, staff is held over on mandatory overtime to fill these unscheduled vacant shifts. As a result, staff morale is low.

Finding: The absence of regular staff also results in interruption of programs, as replacement staff is usually an intermittent employee, who is not trained to facilitate group counseling sessions with wards.

Discussion: The group also said that mandatory overtime (called inversing) could result in a permanent intermittent employee (PIE), being assigned to work in an unfamiliar program. While minimum staff needs are met, the program is impacted because the intermittent is unable to conduct group or individual counseling sessions, due to a lack of training.

Finding: Effective communication and training of staff has been impacted by the lack of budget resources (money).

Discussion: The group said that due to budget constraints, they are unable to conduct staff meetings to ensure that everyone has a clear understanding of operational procedures. This results in staff writing notes in the log or sending email to other staff members as their primary method of communication. Predictably, this mode of communication lends itself to misinterpretation by the reader. Additionally, these staff meetings allow the managers the opportunity to share "lessons learned" from other institutions, as it applies to staff safety issues.

Custody Staff - Interviews with Supervisors

The first and second line supervisors (sergeants and lieutenants) were interviewed at various work locations from August 3-5, 2005.

Finding: The supervisors concurred with the managers. They also said that when regular staff calls in sick, they try to ensure that two (PIE) are not scheduled to work together.

Discussion: They said this becomes challenging when they must move a post and bid regular to work with a PIE in another posted position. The union contract requires that management give seven days advance notice to the employee prior to moving them out of their post and bid position. If it occurs with less than seven days notice, management must notify the union representative.

Finding: The supervisors agreed that the "Open Program" model places a priority on letting the wards out of their rooms.

Discussion: The supervisors were concerned that this emphasis may compromise facility and staff safety. As an example, they said that if a disruption occurred on the dorm (ward on ward fight), staff would close programming. They said staff feels that they must restore the "Open Program", as soon as possible, and sometimes they restore it prematurely.

Finding: The facility does not practice monthly fire drills.

Discussion: Supervisors agreed that there has not been a fire drill in at least two years. They said many of the line staff has never practiced an emergency drill at the facility.

Interviews with Line Staff

The interview team conducted random interviews with line staff from August 3-5, 2005.

Findings: Line staff concurs with managers and supervisors that staff vacancies and inversing staff has led to an increase in sick leave.

Discussion: Line staff said due to staff vacancies and inversing of staff, it is difficult to schedule time off from work, other than regular scheduled days off. They said this is the primary reason staff will call in sick, in order to get a day off. They added that every staff member is inversed, and many are working at least two double shifts a month.

Finding: Personal alarms and radios work intermittently, thereby compromising staff safety.

Discussion: Line staff said the FM alarms don't work in the shower areas or backrooms of the dorms. They informed us that the alarm might activate in 50% to 80% of the instances that staff deploy it. They said the radio transmitters are at least ten years old, and the radio batteries fail to hold a full charge for an entire shift. They said this combination usually results in failed radio transmissions.

Interviews with Treatment Programs

The interview team conducted interviews with staff assigned to the 120-day Substance Abuse program (Lassen), the Residential Substance Abuse Treatment program (Modoc), and, the Sexual Offender program (Yosemite) from August 3-5, 2005.

Findings: These programs are intensified, as they deal with the most difficult and troubled wards. It is essential that there is a sufficient number of qualified and trained staff available at all times.

Discussion: Staff said that it is difficult to meet the program goals (i.e. group and individual counseling sessions). They said due to staff vacancies and illnesses, a counselor is often paired up with a PIE, who is not familiar with the ward population. Oftentimes, the counselor is not able to conduct individual or group counseling sessions, because the wards assigned to the PIE are disruptive on the dorm. The wards take advantage of the PIE, in the same way that students act out when a substitute teacher is present. Because regular staff on the dorms is constantly absent, it is difficult to maintain continuity in the program for the wards. Staff said that the programs require too many services. They said the ward population should be reduced, and/or increase the number of counselors on the dorm.

Finding: Custody staff needs training in how to deal more effectively with mentally ill wards.

Discussion: Treatment team staff said, many times, custody staff is assigned to work in the 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, in the identification, recognition, and systematic approach for dealing with mental health issues.

Finding: Some counselors said that staff safety is compromised when a disruptive ward remains in a dorm.

Discussion: Staff said they frequently have wards in their dorm that refuse to program. They said that wards can be openly defiant and challenging to staff and their objective is to be transferred to the N.A. Chaderjian Youth Correctional Facility. After several DDMS, wards are brought before the Youth Authority Administrative Committee (YAAC), where a finding is made to transfer them from the program. They said that the transfer might take up to three weeks, so the ward is returned to the dorm. They said these wards' presence has a negative affect on the other wards that want to program, and it is increasingly difficult to manage the ward because of the pending transfer.

Finding: Some staff said that counselors isolate themselves in the youth counselor station.

Discussion: As a result, these counselors do not interact with the wards on a personal level. Consequently, they fail to gather intelligence from the wards, which could prevent some misunderstandings.

Finding: Staff are uncertain of their duties during an emergency because they have not participated in emergency response drills.

Discussion: Staff said they would expect the lieutenant and the search and escort officers to show up in the event of an emergency. They indicated they would not know what was expected of them, since they have not received any on hands training.

Interviews with Non-Custody Staff (Central Services)

The interview team spoke with non-custody staff from August 3-5 at the Central Services.

Finding: Staffing and procedures for ward suicide watch at the Outpatient Housing Unit (OHU) should be reviewed by the DeWitt Nelson administration.

Discussion: The interview team was informed that during the hours of 2200 to 0600 custody staff are not routinely assigned to the outpatient-housing unit (OHU). If a ward is placed on suicide watch, the practice is to assign a peace officer (at overtime) to supervise the suicidal ward on a one-to-one basis at the OHU. However, if there are no wards on suicide watch, a custody officer from central services must be present to remove a ward from a room in the outpatient-housing unit. This procedure is compounded by the fact that only one medical person (RN) is assigned to the OHU during these hours and the custody staff coming from central services could be responding to another situation within the three institutional compounds.

It is not uncommon for an at-risk ward to be housed in the OHU. Although this ward may not be placed on suicide watch, ward behavior is unpredictable. If a ward attempted self-harm and medical staff walked by the room and observed the act, the medical staff person could not intervene. The medical response procedure and practice is to request the Central Services Rover to respond to the OHU. Custody and medical staff believe that the OHU should be staffed by a custody officer whenever wards are housed there. The evaluation team concurs and suggests that this issue be reviewed by DJJ Administration.

SUMMARY AND CONCLUSION

DeWitt Nelson Youth Correctional Facility (DWNYCF) was the third Division of Juvenile Justice (DJJ) facility to be evaluated by the Staff Safety Evaluation Team, and immediately followed the evaluation of the O.H. Close Youth Correctional Facility (OHCYCF) and immediately preceded the evaluation of the N.A. Chaderjian Youth Correctional Facility (NACYCF). The three facilities make up the Northern California Youth Correctional Center complex. There were several issues identified during this evaluation that were common to the OHCYCF and NACYCF as well as the Preston Youth Correctional Facility (PYCF) which was the first DJJ facility evaluated by the staff safety evaluation team.

As noted in the OHCYCF report, it is becoming apparent that adequate resources have not been provided to the Division of Juvenile Justice despite the filing of Budget Change Proposals and requests for additional funding (or restoration of funding that fell victim to budget cuts). The lack of resources has negatively impacted staff safety at DJJ institutions. The benign neglect that the team witnessed at PYCF and OHCYCF appears to permeate the Institutions and Camps Division.

In a praiseworthy effort to return to the rehabilitative mission of the DJJ, it appears that staff have lost the authority or ability to discipline wards in a meaningful manner. Many wards recognize that there is little consequence for negative behavior and as such, there is an insufficient disincentive for bad behavior. It must be recognized that many of the wards in the DJJ system are adults who happen to have been adjudicated in the Juvenile Court System. DJJ management should revisit the policies for correcting undesirable behavior of wards to ensure that the policies are effective and appropriate for the ward population.

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 Assistant Superintendent Harada. 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.

CORRECTIONS STANDARDS AUTHORITY
600 Bercut Drive
Sacramento, CA 95814

July19, 2005

Jeff Harada, Asst. Superintendent
DeWitt Nelson Youth Correctional Facility
7650 S. Newcastle Road
Stockton, CA 95213-9002

Dear Superintendent Harada:

CDCR Secretary Roderick Hickman asked the Corrections Standards Authority (CSA) to develop a plan to evaluate staff safety issues in the Division of Adult Institutions and the Division of Juvenile Facilities. At their May 19, 2005 meeting, the CSA 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 staff from the CSA, Adult Operations and Juvenile Justice will be conducting the evaluations over the next 28 months and will be evaluating staff safety at the Northern California Youth Correctional Center on **August 3-12, 2005.** We expect to be on site for eight days and plan to observe operations during all shifts at all three facilities.

We would like to begin with an entrance conference with you and the superintendents from N.A. Chaderjian and O.H. Close and appropriate administrative staff on **August 3, 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 DeWitt Nelson Youth Correctional Facility: (The evaluation team may ask for additional resources, depending on the initial assessment.)

- 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, facility map, facility telephone directory and a telephone. The room should be large enough for a team of nine evaluators.

- 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.

- Copies of all documentation relative to each incident of staff assault including: Incident Reports for Assaults on Staff (CYA 8.403 Behavior Report; CYA 8.412 Serious Incident Report, CYA Use of Restraint Report); State Compensation Reports (SCIF) generated as a result of each incident; Use of Force Review findings. It would be helpful if all documentation relative to each incident was assembled and then indexed in a binder by incident.

- Completion of the data collection form that 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).

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

- Access to copies of applicable operations manuals.

Supplemental Data Sources –

- Facility Health and Safety Committee Minutes*
    - Grievances, Recommendations, Actions
- Staff Action Grievance (CYA)*
- Daily Operations Report (DOR); Notice of Unusual Incident (NOU) at certain facilities*
- Authorized Equipment and Functionality
- Use of Force Committee Minutes and responses to recommendations*
- Employee Training records including summary of curriculum and attendance for orientation and annual updates for selected areas*
- Corrective Action Plans for previous audits*
- Safety Committee Meeting Minutes and Risk Management Action Plans
- Program descriptions and locations
- Administrative Summary of ward population
- Staffing summary including duty roster, allotted positions, vacancies, leave of absence for over 30 days for all staff.
- Staffing profile summary including age, sex, years of service and ethnicity
- Facility design and current capacity

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 August 12, 2005). The results of the evaluation will be reported to the CSA at its regularly scheduled meeting and a written report will be forwarded to CDCR Administration 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: Silvia Huerta-Garcia, Director (A)
Division of Juvenile Facilities

ASSAULT DATA
Jan 2004 through July 2005

Attachment B

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
	1/18/2004	1753	Sun	Glenn	ward hit staff in head	yes	hands	88634	Native amer	general	9/22/2002	5/30/2003	12/11/2005	15	Glenn	None	Noreno		F	SYCC	46	13y 8 m	white
	8/24/2004	2335	Tue	Del Norte	ward hit YCC station screen that hit staff in chin	no	hands	89517	Afr Amer	general	11/19/2003	3/30/2004	3/15/2005	17	Del Norte	None	Crip		F	YCO	46	9y 8m	white
	9/27/2004	1431	Mon	Del Norte	ward hit staff in head	yes	hands	89136		general	8/13/2003	10/23/2003	8/14/2006	15	Del Norte	none	Blood		M	YCC	34	3y 11m	black
	12/6/2004	1105	Mon	School	ward threw a paperback book at teacher	no	book	89725	Hisp	general	2/6/2004	6/1/2004	3/15/2007	15	Glenn	MA List	Sureno		F	teacher	58	4y 10m	white
	12/16/2004	1540	Thurs	Glenn	ward accidently hit staff in head	no	hands	90043	other	general	6/21/2004	12/7/2004	9/14/2005	16	Glenn	none	Sureno		M	YCC	31	7y 6m	black
	4/4/2005	1640	Mon	Inyo	ward spit in staff face	no	saliva	90251	White	general	9/29/2004	12/13/2004	1/13/2006	17	Fresno	Drug	Pecker Wood		M	YCO	35	2y 5m	black
	5/29/2005	940	Sun	Humbolt	ward threw a basketball & hit staff in back of head	yes	ball	89703	Hisp	general	2/18/2004	6/3/2004	11/14/2005	17	Humbolt	Sex Off	Noreno		F	YCC	40	10y 5m	white
	5/30/2005	1918	mon	calaveras	ward threw a shoe & hit staff in chest	yes	shoe	89136	Afr Amer	general	8/13/2003	10/23/2003	8/14/2006	15	calaveras	none	Blood		F	YCC	53	22y 4m	white
	5/20/2005	1710	Wed	Preston - Ironwood	Battery on Staff (foreign substance)	no	foreign substance	90251			unknown	unknown	unknown	17	Preston - Ironwood	Unk	Unk		M	PA	41	17y 7m	white
	7/25/2005	950	Thurs	school lobby	Escorting restrained ward he mule kicked staff	no	foot	90426	Afr Amer	general	1/11/2005	4/6/2005	2/14/2008	15	El Dorado	none	Crip		M	YCO	54	31y 5m	black

CORRECTIONS STANDARDS AUTHORITY – STAFF SAFETY EVALUATIONS
Institutional Information
LIVING AREA SPACE EVALUATION

FACILITY: DeWitt Nelson	**TYPE:**	**DATE:** 8-3-05

Building/Housing Unit							**Each Building**			
Location	Cell Type	Design Capacity	# Cells	EACH CELL		Pop on this day	Program/Security Level	Staffing		
				Beds	E Beds			1st	2nd	3rd
Lassen	Dorm	50	3	50	7	51	120 day drug treatment program	1	3	3
Modoc	Dorm	50	3	50	18	58	6 month drug treatment program	1	2	3
Tahoe	Dorm	50	3	50	25	61	Work experience program. One additional staff works a crossover shift between 2nd and 3rd watch.	1	2	3
Yosemite	Dorm	50	3	50	25	63	Sex offender program. One additional staff works a crossover shift between 2nd and 3rd watch.	1	2	3
Plumas	Dorm	50	3	50	22	57	Parole violator program. One additional staff works a crossover shift between 2nd and 3rd watch.	1	2	3
Klamath	Dorm	50	3	50	22	59	General population unit. One additional staff works a crossover shift between 2nd and 3rd watch.	1	2	3
Sierra	Dorm	50	3	50	10	60	General population unit. One additional staff works a crossover shift between 2nd and 3rd watch.	1	2	3
Angeles	Dorm	50	3	50	25	0	This unit was closed due to damage sustained in riot.	0	0	0
Security and Escort								2	2	2

Note:
Each unit contains one locked single cell. Each cell contains a combination unit and a camera.

DeWitt Nelson Youth Correctional Facility
August 3 – 5, 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 many years do you have as a supervisor?

2. How long have you been assigned to this facility 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. What safety equipment is issued and carried by your staff?

9. Is there any other safety equipment, which you know of, available for staff's use? What is it?

10. Do you have a stab vest? Have you been fitted for one? Do you wear it at all times?

11. Does your staff have stab vests? Have they been fitted for one? Do you ensure that they wear it at all times?

12. How often do you see your supervisors?

13. 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?

14. What is your greatest concern about staff safety for your subordinates?

15. What kind of complaints do you get from staff? Are there any patterns that emerge? How do you handle them?

16. What do you do to ensure a safe working environment for your staff?

17. What would you like to do or see changed to improve staff safety and reduce staff assaults?

18. What protocols in place for emergency responses?

19. 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 many years experience do you have as a manager?

2. How long have you been assigned to this facility 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?

7. Is there any other safety equipment, which you know of, available for staff's use? What is it?

8. 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?

9. 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?

10. From your perspective, what carries the greatest potential for staff injury?

11. What might mitigate or reduce staff assaults?

12. What kinds of complaints do you get from staff? Are there any patterns that emerge?

14. Do you have any long range plans to ensure staff safety and to reduce staff assaults?

15. Do you have anyone assigned to monitor staff assaults or track occurrences to identify trends?

16. 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?

17. Have the number of vacancies, SCIF 3301, other leave of absences affected staff safety? Do you have mandated overtime for staff and supervisors?

18 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?

19. 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?

20. What protocols in place for emergency responses?

21. 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

Evaluation Team Members
Northern California Youth Correctional Center

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Jeff Plunkett, Division of Juvenile Justice, Captain

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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:
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