



N.A. Chaderjian
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 (DWNKYCF), 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

The N.A. Chaderjian Youth Correctional Facility (NACYCF) was selected as the fourth juvenile facility for review and an entrance letter was sent to Eric Umeda, Acting Superintendent, informing him of the July August 8-12, 2005 site visit dates and the proposed operational plan (Attachment A). After the initial examination of documentation and interviews with NACYCF staff, the evaluation team requested an additional week to complete the review. With the one-week extension, this review was conducted during the weeks of August 8-12 and August 15-19.

The criteria panel had suggested using a data matrix to record information from the Serious Incident Reports (SIR) for staff assault or attempted assaults by wards to determine if any trends could be identified. The institution staff was asked to review the reports and complete the matrix before the site visit. (See Attachment B). The evaluation team asked that all incident reports and related documentation be made available during the site visit. As the evaluation progressed, the team identified other information appropriate for review and staff at the institution provided copies of existing documents, or researched their records for information.

The Facilities Standards and Operations Division of the CSA led the evaluation team. The team was divided into three work teams, each comprised of staff from the CSA, Adult Operations and Juvenile Justice Division (each team had a member from each discipline – see Attachment E for a roster of team members and assignment).

The evaluation began at NACYCF on August 8, 2005, with an entrance conference with appropriate institutional administrative staff and evaluation team members. The conference included an operational overview of the institution by Superintendent Umeda as well as an overview of the evaluation process by CSA Field Representative Bob Takeshta.

Using a conference room in the NACYCF satellite medical unit as the base of operation, the team broke into workgroups and began the review process but continued to meet daily to discuss their observations. Available documentation was reviewed relative to the physical plant configuration, policies, safety equipment, staffing levels, staff assaults and ward population. The group looked for any trends or related issues.

The physical plant team reviewed the institution design as it related to staffing, and the ward population. The purpose was to identify any issues that would affect staff safety such as crowding, limited visibility, insufficient supervision or lack of communication.

Facility managers as well as staff and supervisors on each of the three watches were interviewed to provide an opportunity to identify their concerns regarding staff safety issues. A questionnaire was developed in preparation for the review to ensure some consistency among the interviews and is included as an attachment to this report (see Attachment D). The responses were categorized and a summary of the responses is included in the Staff Interview section of this report (pages 31-37). 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

N.A. Chaderjian Youth Correctional Facility (NACYCF) is located within the Northern California Youth Correctional 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.

Current Usage

Initially opened in 1991, NACYCF houses wards between the ages of 18 through 25 who require higher custodial and supervision needs accommodated by the special management programs (SMP). Several special programs are offered at NACYCF to serve the wards' needs.

- **Sacramento Hall-Unit I.** Houses wards assigned to the Special Management Program (SMP). These wards are eligible for this program due to criteria set forth in the Department's restricted program policy which requires a more controlled and secure housing unit due to aggressive or violent behavior.
- **Kern Hall-Unit I.** Houses wards assigned to the SMP and wards on temporary detention from other halls and SMP wards awaiting completion of criminal court cases. The Kern Hall located within Unit I has a unique dayroom feature. A wall bifurcates the dayroom allowing for smaller groups of wards.
- **Merced Hall-Unit II,** Intensive Treatment Program (ITP). Houses ITP wards with severe emotional and behavioral disorders requiring a full range of psychological and psychiatric services.
- **McCloud Hall-Unit II,** Specialized Counseling Program (SCP). Houses wards that require intense psychotherapeutic services or those diagnosed as emotionally disturbed. Treatment modalities used are rational behavior therapy, cognitive restructuring and relapse prevention. In addition to the above mission, McCloud Hall also houses wards who are hearing impaired and communicate via American Sign Language.
 - Units I and II contain two classrooms each and Unit II contains a nurse's station.
- **Feather Hall-Unit III,** Sex Offender Program (SOP). Houses wards assigned to the formalized sex offender program who are mandated to participate in a sex offender program prior to their release.
- **Mojave Hall-Unit III,** Parole Violators and overflow for DWNYCF. Mojave houses wards who have been returned to custody on a parole violation and newly assigned wards to NACYCF.

- **American Hall-Unit IV**, General Population - Gang free program. American Hall houses wards who are not involved or have not been identified as being gang members or associates. Wards requiring protective custody are housed in this unit.
- **Smith Hall-Unit IV**, General Population (GP). Smith Hall houses Fresno Bulldog gang members and other wards.
- **Owens and Pajaro Halls-Unit V**, General Population (GP). Owens and Pajaro Halls house general population northern Hispanic wards and other wards.
- **San Joaquin Hall-Unit VI**, General Population. San Joaquin Hall houses general population northern Hispanic wards and other wards.
- **Tuolumne Hall, Unit VI**, Substance Abuse Treatment Program (SATP). The SATP is a 6-month program for the treatment of addictive behaviors and chemical dependency. Individuals are expected to participate in and complete a curriculum providing treatment and training delivered through a therapeutic community model. Participating wards are immersed in an intense program of recovery utilizing psychosocial, physical, and education modalities during the last 6 months of their program.

Population Summary

The ward population at NACYCF has fluctuated over the years, depending on numbers of wards in the CYA system and the availability of programs. The design capacity as rated by the Division of Juvenile Justice (JDD) is 600. The maximum bed capacity is 800. At the time of our evaluation, the institution housed 487 wards including 122 wards with mental health needs, eighty-eight of which range from moderate to high suicide risk.

The wards' ages range from 17 to 25 and the average age is 19.7. Five wards are under 18 years old.

- Seventy-nine percent of the wards at NACYCF are categorized as being assaultive;
 - Fifty percent of wards are considered to be escape risks;
 - Thirty-two percent of wards have been committed for crimes involving sexual assault;
 - Seventy-one percent of wards have documented gang affiliations; and,
 - Forty-five percent of wards have histories of substance abuse.
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- Thirty-two percent of the ward population is Hispanic;
 - Forty percent of the ward population is black;
 - Twenty-one percent of the ward populations is white;
 - Four percent of the wards populations is Asian;
 - One percent of the ward population is Filipino; and,
 - One percent of the ward populations is classified as "other".

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. Another goal for the program at this facility is to maximize the out-of-cell time for wards.

Staffing Allocation and Availability

Management staff at NACYCF consists of the Superintendent, an Assistant Superintendent and a Major who is designated the Chief of Security at the facility. The funded staffing allocation at NACYCF is 222 custody personnel, which includes the management staff, Program Administrators, Lieutenants, Sergeants, Senior Youth Correctional Counselors, Youth Correctional Counselors, Youth Correctional Officers, Parole Agent I/III, Case Worker Specialists and Medical Technical Assistants (MTA). NACYCF has 11 vacant custody positions and 40 custody personnel are off work on extended leave (3 months or more). There are forty-seven Permanent Intermittent Employees (PIE) who do not occupy permanent positions but are available as needed for assignment.

Included among the vacancies are the Superintendent and Assistant Superintendent positions. One Program Administrator currently acts in all three capacities.

Of the 92.2 non-custody position allocations, there are currently 18 vacancies and 4 non-custody employees are off on long-term leave (over 3 months). See Table I below for a summary of positions, vacancies, long-term leave and staff availability.

Table I				
	Allocated Positions	Vacancies	Long-term Leave	Available Staff
Custody Staff	222	11	40	189/20 PIEs
Non-Custody Staff	92.2	18	4	77.2
Total	314.2	29	44	313.2

PHYSICAL PLANT, STAFFING & POPULATION

NACYCF is located in a 450-acre complex that includes three other youth correctional facilities, O.H. Close Youth Correctional Facility (OHCYCF), DeWitt Nelson Youth Correctional Facility (DWNKYCF), and Karl Holton Youth Correctional Facility (KHYCF). The Holton facility is currently closed due to a decrease in the Juvenile Justice Division's total statewide population. NACYCF was built in 1991 utilizing 270-degree design buildings. The facility has six housing units, with each unit being divided with a solid wall into two distinct living units called halls. Each unit contains a dining room that is shared by the two halls. Each hall has 50 cells total, 25 on the upper tier and 25 on the lower tier. A central control unit, chapel, educational classrooms and vocational spaces are situated around the recreation field within the secure perimeter. A single fence surrounds NACYCF with a second fence surrounding the entire NCYCC complex.

Each of the living units has similar design configurations. A control booth tower is centrally located within each unit and is elevated above the living area. The six control booth towers are critical to the safe operation of the housing units. The control booth towers are secured post positions which also have an inventory of chemical and less lethal weapons for use during emergencies. The height of the control booth towers allows for direct visual observation of ward activities and provides a protected location for staff, communications/electronic equipment, and all other emergency equipment requiring secure storage.

All of the buildings are separated by sufficient distances that search and escort officers use vehicles to provide routine and emergency services to the housing units, chapels and educational buildings. Youth Correctional Officers (YCO) are assigned to the vehicle posts to control ward movement and escort within the secure perimeter.

The evaluation team was unable to identify the classification level of the wards housed within the facility due to the lack of a classification system within the Division of Juvenile Justice. We were told many of the wards required the highest level of security offered by the agency.

Educational services are provided onsite and within the secure perimeter. NACYCF currently employs 45 staff assigned to providing academic education and 8 vocational instructors teaching trades skills. The education department staffing includes Psychologist, credentialed teachers, credentialed special education teachers and vocational instructors. NACYCF offers a variety of educational programs which include 11 full-time academic classes and special educational programs. NACYCF also provides vocational training which includes; culinary arts, office support, graphic arts, barber skills, building maintenance, heating/air conditioning/ventilation, and auto mechanics. Some of the classrooms are dedicated to vocational education programs.

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 twelve. MTAs are assigned to the OHU.

The physical plant 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.
- Staff use towels to dam up leaks in an attempt to avoid puddling on the dayroom floors.
- Standing water and large puddles of mud were observed throughout the facility grounds created by leaking irrigation water lines and/or poorly operating sprinklers.
- 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.

STRUCTURAL

- Doorframes are severely rusted in the shower area. In some cases, the frames allow for pieces of metal to be pried away and used as weapons.
- 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.
- Large populations of 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 creating 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 loose 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 was not increased in 1991 when the NACYCF facility opened. Currently, there are 44.5 maintenance personnel assigned to the complex and only 28 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 decipher which work orders were addressed and which ones were still outstanding. The best example to illustrate this problem is in Unit I where leg shackles were applied to the sleeping room doors by the staff as a means of securing them. Plant Operations demonstrated how and when repairs were made to these doors, but the facility staff was either unaware or unconvinced of the repair. 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: Plant Operation staff has indicated that the original facility construction was substandard in several building trades. Improperly installed wiring for security devices and complete electrical systems; HVAC systems that were ten years old when installed; block walls that were not filled with concrete and substandard plumbing were highlights of discussions. In many instances maintenance is not the issue, but complete replacement of entire systems is needed.

Discussion: Immediate funding appropriation is needed to expedite repairs desperately needed in each unit of this facility. Plant Operations has detailed the needed repairs and has repeatedly submitted requests for these repairs.

Finding: Staff reported that the wards have the ability to defeat the locking mechanisms on all of the sleeping rooms within this facility.

Discussion: Documentation was provided detailing wards exiting sleeping rooms that were locked. Staff demonstrated to evaluation team members the techniques utilized to defeat the sleeping room door locks by the wards. Given the criminal sophistication of the wards housed at this facility, providing secure housing is essential for the safety of staff and wards. The evaluation team members recognize that some of the sleeping room locks are failing due to the

lack of preventive maintenance; however, the original design of the locking system is inadequate for the security level of ward currently housed.

Finding: Unit I, Sacramento and Kern recreation yard fences are not suitable for use due to the material used and the methods used to secure the individual recreation area (IRA) enclosures.

Discussion: Six small IRA enclosures are divided with chain link fencing and covered with a tin roof. There are seven documented incidents in 2005 in which wards have breached the yard enclosure (chain link) and have assaulted other wards and staff. The wards unravel the chain link to create holes big enough to crawl through, or they kick the bottom section of the fence to break the bond between the concrete and chain link material. Unit staff have made their own repairs by mending the fence with “Flex Cuffs” to accommodate out of cell outdoor exercise for Unit I wards. All (100%) of the seven incidents resulted in the use of force by staff to gain control of the combatants. In one incident, wards sprayed 5 staff members with unknown liquid substances. Each of the 5 staff members were treated for blood borne exposure.

Plant Operations is aware of this issue and has invested numerous personnel-hours repairing these recreation areas. Due to the poor design of these recreation areas, wards can cause damage faster than maintenance can make repairs.

Plant Operations staff indicated their concerns of the inadequate design and materials when the IRAs were initially proposed. Plant Operations staff presented the schematic design drawings of the secure individual recreation areas utilized by CDCR Adult Institutions to the CYA design team responsible for the IRAs; however, those plans were rebuked in favor of the current, substandard design. Requests for funding to construct adequate individual secure recreation areas have been denied.

Finding: The security perimeter fences surrounding the exercise yards of Units II, III, IV, V and VI are not secure.

Discussion: The razor wire used to top the fence is inadequate and improperly installed. The razor wire and fence currently in place do not deter breaches or escapes. The outside recreation area fences should be upgraded to a level consistent with the security level of the current ward population.

Finding: Partitioning the current living units and creating four halls within each unit is a cost effective means of reducing the number of wards within each hall, increasing staff and ward safety and enhancing program opportunities.

Discussion: All of the living units (except the Kern Hall) have similar design configurations. The Kern Hall was bifurcated as part of the original design as a means of reducing the number of wards programming in a dayroom at one time. An equal number of showers are provided on either side of the partition wall and the observation lines of the control tower staff are not restricted by the partition. Given the similar design of the other units, the dayrooms of other halls lend themselves to similar remodeling possibilities.

Reducing the number of wards involved in any type of behavior modification program is accepted nationwide as a best practice. Wards with high levels of criminal sophistication in groups as large as fifty are difficult to manage. Recommendations for reducing the number of wards programming in the dayroom at one time have previously been made by other groups. Smaller units tend to require more staff overall and the additional staffing costs would need to be considered.

Finding: Floor drains are not provided in any of the units. Wards are able to substantially flood the halls.

Discussion: Staff reports that several inches of water have been observed at times on the dayroom floors due to wards causing flooding. The team members recommend facility managers plant operations staff explore the possibility of providing floor drains in dayrooms of each hall or some other measure to quickly drain a flooded room.

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: Several vacancies exist among the management staff at NACYCF. This is particularly noteworthy considering that this facility houses some of the most difficult to manage wards and is the recipient of intense media scrutiny regarding allegations of poor management, employee misconduct and excessive violence.

Discussion: The Superintendent and Assistant Superintendent positions are vacant. The Program Administrator is acting in both capacities and performing his duties as a Program Administrator. All three positions are critical to the operation of both NACYCF and the NCYCC complex. The team thought a priority should be placed on making permanent appointments to these vacant positions.

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 207 correctional officers/counselors per month has 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 following a change in the employment contract. During April of 2005, the records reflect 337 custody personnel were ordered to work an overtime shift by inverse seniority (inversed). The team was told the numbers have since increased to nearly 400 shifts per month being covered by staff ordered to work a double shift. The Superintendent reported that they are starting a new schedule each month with 275 uncovered shifts. Intermittent employees can cover many of the 275 shifts but then another 300 employees call in and request sick leave. Even the

Permanent Intermittent Employees (PIE) are mandated to work overtime. An average of 29 PIEs were inverted each month in 2005.

When shifts cannot be filled with volunteer overtime or part-time intermittent employees, staff must be “inversed” or ordered to work overtime through the next shift. 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.

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

Discussion: NACYCF has 18 vacancies among the allotted 92 non-custody positions. Of particular concern, 14 of the 61 educational staff positions are vacant and 4 more have been off for more than 3 months. The team was told teachers are not replaced when they are absent from work and the class is cancelled. When wards are not in the classroom, they remain in the living units where custody staff is at a minimum and no other programming options are available. The evaluation team observed several wards not attending school during school hours. In an effort to provide education to wards that remain on the hall, the teachers take the classroom to the housing units. Following a short presentation (usually less than 15 minutes per ward) by a teacher outside of the ward’s sleeping room door, the wards were left with “in room” study materials.

NACYCF is in the process of filling those positions via the testing and interview procedures. Education management staff did express concern pertaining to the retention and unavailability of substitute teaching staff.

Supervising wards returned from class 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: At times, there are too few Security and Escort staff to safely respond to emergencies within the facility.

Discussion: There are only three Security and Escort staff assigned to each watch that are able to respond to emergencies. At times, multiple alarms occur simultaneously within the facility. Additional Security and Escort staff should be assigned to each watch.

Finding: Additional staff should be assigned to Units III, IV, V, VI and McCloud Hall in Unit II.

Discussion: On Units III, IV, V, VI and McCloud Hall in Unit II, three staff are assigned as floor officers; however, frequently between the hours of 0600-1000 and between 1800-2200 there are only two staff working as floor officers. This is not a sufficient number of staff for these units given the sophistication of the wards detained.

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: 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 the supervisor's 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: The facility housing unit control booths should not be staffed with YCCs.

Discussion: With the exception of Unit I, unit control booths are staffed with YCCs. YCCs' primary function is to provide counseling and treatment to the ward population. Providing this service is difficult, if not impossible, from the control booth. The evaluation team recommends staffing all control booths with YCOs on all three watches. The presence of YCOs in the control booths will provide the units with a security staff member at all times. In addition it will free up the YCC staff members so that they can facilitate the necessary counseling and treatment programs.

Finding: The staff use of vehicles to monitor ward escort/movement and to perform 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 (car, truck, van). 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.

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 during the initial 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 use 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 DJJ 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: The Institutional Policy Manuals and emergency procedures need to be created, reviewed and/or updated.

Discussion: The Institutions Multi-Hazard Emergency Plan (Restricted Emergency Operational Procedures) has not been updated or revised since February 2003. In addition, the emergency mutual aid plan needs to be updated to contain current and correct information in addition to a review of contingency plans for the detailed deployment and utilization of outside resources in the event of an emergency. None of the emergency procedures reviewed contained origination dates, revision dates, or signatures of authority on the specific procedures. Absent these indicators, 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.

The facilities operational procedures have not been revised or updated since March 11, 1999. The procedures do not include a written plan to visually account for staff once inside of the facility or on duty during emergency situations that would require a welfare check of employees or visitors. The institution currently utilizes the "In and Out" System to process employees and visitors by retaining the individual's identification card. However this system does not account for the staff member's actual location or well being once inside of the institution.

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 matters 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: 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: 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: 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: 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: 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: Wards housed at Sacramento Hall, who are restrained when out of their rooms, are allowed to participate in the academic classroom unrestrained. There are inadequate staff in the classroom to quell a disturbance if these special management wards were to act out violently.

Discussion: Wards housed in Sacramento Hall are considered special management program due to their history of behavioral problems. These wards are in restraints when out of their assigned sleeping rooms for any movement. The review team noted that when processed to the education classroom, the restraint equipment is removed and the wards participate in the education program unrestrained. The education program allows up to five wards to participate per period.

There is one YCO and one education teacher in the classroom supervising the five wards participants. Should an incident occur, one staff might not constitute adequate staffing to control five unrestrained wards that have been identified as having behavior problems warranting a

special management program, jeopardizing the safety of wards, education staff and the officer present.

Finding: A tour of the NACYCF facility sub-armory revealed there is no accurate system in place to account for munitions, weapons and related emergency equipment. There is no accountability of staff entering and exiting the armory. Maintenance records are non-existent and staff responsible for the armory have not received any specialized training for the upkeep and maintenance needs of munitions, weapons and equipment. Many of the same conditions are present in the central armory.

Discussion: The central armory is located in the Northern California Youth Correctional Center (NCYCC) complex near the entrance gate. The central armory is constructed of concrete and cinderblock that appears to be a sound and secure location site for armory operations. A single chain link fence topped with adequate razor wire to stop or slow intruders surrounds the armory. The central control building monitors dedicated cameras which provide visual observation of the front door and one camera monitors the inside of the armory 24/7.

The staff member assigned to the central armory has several other duties not related to armory functions. Other critical assignments leave little or no time for the maintenance and inspection of munitions, weapons and emergency equipment stored in the sub-armory or in service throughout the facility. Formal training for the cleaning, inspection, and maintenance of armory related items have not been provided to the staff member assigned to the duties and responsibilities for armory related equipment. The armory staff member also said because of other priority duty assignments, he does not spend more than a few hours every few months taking care of the maintenance and inventory of armory related items.

The sub-armory appeared very disorderly and in need of appropriate storage and organization of current inventories. The last log entry on the staff sub-armory entrance and exit log was on 6-21-05, additionally, the review team was not asked to sign in and out.

Inventory sheets are not being utilized for the accountability of munitions, weapons, or equipment. Additionally, when munitions are rotated or replaced, there is no way to verify the accurate inventory. Monthly inventories and reconciliations are not being conducted to account for expended and unserviceable munitions and equipment. There is no record of recent internal audits to verify the accuracy of the armory's inventory. It would be difficult to determine if equipment, munitions, or weapons are missing.

Maintenance records of related sub-armory supplies were not available, NACYCF staff indicated there is no maintenance schedule nor has any staff received training specific to the maintenance or repair of these items.

Staff informed us that an inventory and reconciliation of items has not been conducted in several months. An armory entry/exit log was not present during the review. The approved form (State Property Inventory) to list and inventory state property was not available and is not being used. The inventory process used is maintained on a computer in the central control complex; no hard copies were located or maintained in the central armory. It would be difficult to determine if equipment, munitions, or weapons are missing.

The evaluation team recommends that procedures are developed to use and maintain facility armories and that sufficient resources are devoted to the armories, and that periodic management reviews are conducted concerning armory operations.

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 19-month period January 2004 – July 2005.
- 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).
- Multi-Hazard Emergency Plans.
- Institutions and Camp Manual.
- Institution Operation Manual.
- Administrative Summary.
- OBITS Report.
- Work Order Logs.

Staff Assault Incident Reports

Finding: After a collective review and discussion of the above listed documents, there were notable statistics which indicate gang influence as being responsible for an alarming number of staff assaults.

Discussion: The majority of staff assaults appear to have been committed by known gang members or associates, or were influenced by gangs. In the 12 months of 2004, there were 45 staff assault and batteries reported among 35 incidents. In the first seven months of 2005, there have already been 37 incidents with 41 staff members being victims of assaults by wards. The increase of staff assaults in 2005 was influenced by those occurring in the month of July when 14 staff assaults were reported. Of the 14 assaults in July 2005, nine (64%) were committed by wards identified as “Nortehños”, the name used to identify a Northern California Hispanic gang. The evaluation team noted that the Nortehños dominate the Hispanic ward population; wards from the Southern California region are housed in Housing Unit I, Special Management Program.

Finding: Wards at NACYCF with gang affiliations are more likely to commit assaults on staff.

Discussion: Of the 78 incidents reviewed, sixty-nine (88%) involved wards with gang affiliations. The following table illustrates the number of incidents by gang affiliation:

Gang Name	# of Incidents	Percentage
Noteños	30	38%
Crips	12	15%
415/Bay	12	15%
Bloods	8	10%
Whites	4	5%
Fresno Bulldogs	3	4%
No gang affiliation	9	12%

Several of the reports reviewed included statements made by the assailants following the assault that make reference to gang influence and power. The majority of the statements involved Norteño gang references.

Finding: Wards in special management programs and Norteño gang members are responsible for the majority of staff assaults.

Discussion: Of the 78 incidents, 51 (65%) occurred in Housing Unit I. Unit I houses the Special Management Program (SMP) in Kern Hall and the Restricted Programs in Sacramento Hall. Of the 51 staff assault incidents that occurred in Unit I, 29 (57%) occurred in Kern Hall and 22 (43%) occurred in Sacramento Hall.

Housing Unit V, specifically Pajaro Hall, houses general population northern Hispanic wards. Of the 78 incidents, 13 (17%) occurred in Pajaro Hall. Of the 13 incidents of staff assault reported in Pajaro Hall during the nineteen-month review period, 5 (38%) occurred during July 2005.

Finding: The majority of staff assaulted during the review period were peace officer classifications (94%) and 78 (92%) of the victims were male.

Discussion: Seventy-eight incidents of battery and attempted battery on staff were reported during the time period, January 1, 2004 through July 21, 2005 at NACYCF. Of these 78 incidents reported, 89 staff members were victim to the assaults.

The victims included employees of several classifications including:

- o 8 Senior Youth Counselors.
- o 33 Youth Correctional Counselors.
- o 31 Youth Correctional Officers.
- o 5 Lieutenants.
- o 2 Parole Agent.
- o 1 Case Worker Specialist.
- o 2 Teachers.

- o 1 Teachers Assistant.
 - o 1 Psychologist.
 - o 1 Academy Cadet.
- The victims included 82 males and 7 females.
 - The race of the victims included:
 - o 35 white.
 - o 18 black.
 - o 28 Hispanic.
 - o 6 Asian.
 - o 2 Filipino.

Black officers are underrepresented as victims of assaults. The facility actually has nearly an equal percentage white, black and Hispanic officers but black officers were involved in assaults at a lower percentage. Of the 89 staff assaulted, the average age of the staff members was 39.8.

Finding: Time in custody at NACYCF could be an indicator of the profile of assaultive wards.

Discussion: The team compared the age, race and length of time in custody of the staff assaultive wards to that of the overall ward population. Hispanic wards were involved in 29 incidents, black wards were involved in 33 incidents, white wards were involved in 13 incidents, Filipino wards were involved in 2 incidents, and 1 incident was listed as other. In comparison to the overall ward population, the statistics are not significantly different.

The average age of wards involved was 19.3; much the same as the facility entire population's average age of 19.7.

A review of the intake data revealed that wards appeared to be more aggressive during the first nine months following their arrival at the NACYCF facility. In reviewing the data for the first seven months in 2005, the following relationships were noted.

- 0 – 3 months at NACYCF, 15 (41%) wards were involved in assaults.
- 3 – 6 months at NACYCF, 9 (24%) wards were involved in staff assaults.
- 6 – 9 months at NACYCF, 6 (16%) wards were involved in staff assaults.
- 9 – 12 months at NACYCF, 3 (8%) wards were involved in staff assaults.
- 12 months or longer at NACYCF, 3 (8%) wards were involved in staff assaults.
- One attacker was not identified.

Finding: The number of staff assaults has shown a significant increase since at NACYCF between April and July 2005 as compared to a similar time period in 2004.

Discussion: Staff assaults reported during the first and second quarters of 2004 and 2005 were compared. A significant increase is noted during the second quarter of 2005 over the previous quarters.

Dates	Staff assaults
January 2004 through March 2004	4
April 2004 through June 2004	8
July 2004	3
January 2005 through March 2005	7
April 2005 through June 2005	15
July 2005	10

The “Open Program” began on April 1, 2005 and may have been a contributing factor to the increase in staff assaults. An unrest among the Norteño gang may have also been a contributing factor.

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

Discussion: Thirty-seven incidents occurred during second watch between 0600-1400 and forty-one incidents occurred during third watch between 1400-2230. No staff assaults occurred during first watch. For the purposes of this evaluation, the review team examined 78 serious incident reports (SIR) involving 89 staff battery/assaults from January 2004-July 2005, a nineteen-month period. The frequency of incidents was highest during months of the year typically having high temperatures, specifically July and August. The most notable month was July 2005 with 14 staff assault incidents reported. Assaults in August of 2005 were not reviewed during this evaluation, however 10 incidents were reported during August of 2004.

Facility staff have documentation to support that the increase in the number of staff assaults in July 2005 is directly related to on going problems with the Northern Hispanic population. As mentioned previously in this report, the wards identified as being members of or aligned with the Norteño gang were responsible for 9 (65%) of the 14 staff assaults which occurred in July of 2005, and 20 (54%) of the 37 incidents during the 7-month period reviewed in 2005.

The days of the week with the greatest number of incidents were Tuesday and Wednesday. The remainder of the incidents were divided among the other days of the week with Saturday being noted with the least amount (5) of staff assaults. Twenty assaults (26 percent) were reported between the hours of 6-10 pm, nineteen (24 percent) were reported from 10-12 am, and all others were equally divided during all other hours of the day with the least amount occurring during the hours from 6-10 am.

Finding: Wards assault staff in an effort to be transferred to an adult facility.

Discussion: In some cases, references were made by wards to the effect that they were “wanting to go to the pen”. In one case, the ward wanted to make sure the officer noted in his file that he had assaulted two staff members and not documenting only the victim that was directly assaulted.

Finding: A variety of assault methods were used against staff members; the majority of which were "gassings".

Discussion: Of the 78 incidents reviewed, 1 (one percent) involved a staff member being sliced with a ward manufactured weapon, 34 incidents (forty-four percent) involved 39 staff members being showered with unknown liquid substances (gassed), 34 incidents (forty-four percent) involved 38 staff members being battered with fists, hands and feet, 15 (nineteen percent) involved staff members being spat on by wards, 1 incident (one percent) involved sexual battery where the ward inappropriately touched a teacher on the buttocks, and the final incident (one percent) involved a staff member being struck with a container of food.

Finding: Data on the subject of staff assaults at NACYCF identifies the majority of staff assaults are related to the staff member having unknown liquids thrown on them or being spit on. In addition, there are an alarming number of the staff assaults that are committed via the sleeping room food ports.

Discussion: Twenty-seven incidents involved assaults performed via the food ports located in the sleeping room doors. Originally designed to provide a higher level of officer safety, the food ports are used to pass food, medication, and supplies to wards without the necessity of opening the room door. The ports provide an opening to allow verbal communication as well as a means to secure or release mechanical restraints. Unfortunately, the ports also provide an avenue for wards to gas staff. Often the food ports are not closed, or the locking mechanism fails to secure in the closed position and the ward can throw liquids on staff. Staff need to always secure the food slot door in the closed position and faulty locking mechanisms need to be repaired immediately.

Finding: Staff are targeted by wards for assaults.

Discussion: In reading the reports of staff assaults, sixteen of the assaults appear to be in retaliation for corrective action taken by staff. In many cases, the wards made statements to that effect. In others, the attack took place following a disciplinary action, corrective counseling or while a disciplinary notice was being served to the ward. In 3 cases, the victim was baited to come closer to the door to "talk".

In many cases, the officers were ambushed with no indication that an assault was imminent. Absent an argument, an altercation or other activity that would give notice to the officer of a pending problem, officers find themselves gassed when performing routine duties. Eighteen assaults occurred during food service, medication pass and while passing out supplies. Twelve assaults occurred while the staff members were performing routine safety checks of the rooms, a task they perform every 30 minutes.

Seven officers have been assaulted on multiple occasions since October 2004. Six have been assaulted on two occasions. One YCO has been assaulted 3 times in less than 10 months.

Finding: Statistics provided by the risk manager and safety officer support the need for increased training in areas including universal precautions, cell food port operations, work area awareness, use of emergency equipment, 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: The Serious Incident Reports reviewed from January 1, 2004 through July 31, 2005, revealed that many incidents have resulted in serious injuries.

The safety officer reported the following statistics:

- Forty staff are currently off work on long term leave (more than 3 months).
- Thirty-five are off work as a result of injuries sustained on duty.
- Twenty are off as result of staff assault, responding to emergencies or injuries sustained while taking action necessary at the scene of an emergency.
- Ten have filed for retirement.

Finding: Safety meetings are under attended.

Discussion: The safety officer holds monthly safety meetings; however, few people attend. One month, only the safety officer and two other staff members attended. For unknown reasons, the risk manager is not invited to the meetings. The meetings minutes do not provide sufficient information to determine how safety concerns are addressed. Follow up discussion and action plans to improve safety and reduce staff injuries were absent in much of the documentation reviewed by the team.

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 NACYCF was provided 20 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:

- CPR, 4 hours
- Inappropriate relationships, 1 hour
- Infectious disease, 2 hours
- Respirator protection, 3 hours
- Use of force, 2 hours
- Suicide prevention, 1 hour

- Staff accountability, 1 hour
- Open Program, unknown duration
- Illness/Injury prevention program, 2 hours
- Code of Silence, 1 hour
- Department reorganization, 1 hour
- Education, 1 hour
- Other miscellaneous training classes including, Effective interaction, Fire Safety and Emergency Preparedness.

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

Discussion: The 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 have been attended that include subjects such as, control holds, restraint application, defensive tactics, weapon take-aways, weaponless defense, and chemical agents.

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

Discussion: The Institutional and Camps policy manual specifies that all YCC and YCO staff are to receive 16 hours of annual training. In the training records reviewed, the team was able to identify few annual training classes that could be considered somewhat specific to the subject of ward counseling and all were under attended. Only 8 employees attended a class entitled, “Casework Management”. Only 7 employees attended a class entitled, “DDMS/Ward Grievances”. Only 4 employees attended a class entitled, “Signs/Symptoms of Mental Illness”.

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, tactical team or those positions allowing/requiring the use of a baton are required to attend 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. All YCO staff at NACYCF are issued side handle batons although not all choose to carry them. While the firearms training requirements are being satisfied, the training records reflect that only 3 staff members have received the annual baton update training, though the Training Manager was certain that no staff members have received baton training since 2002.

Finding: Tracking attendance and ensuring all persons actually attend training as scheduled remains a challenge for the Training Manager. The team members were concerned that not all officers were trained on the appropriate subjects.

Discussion: Few training classes were attended by all staff. The training on Open Program, Respirator Protection and Use of Force appeared to have been attended by all staff. CPR was also well attended; however, only 202 out of 388 employees (270 officers, 76 education staff and 42 support staff) that work in the facility received the training. It was difficult to determine the

attendance rate for most of the training classes. It was not known to the coordinator how many people were scheduled to attend most classes. The overall attendance rate for the four classes which had accurate attendance records was about 70 percent. Infectious disease and illness/injury protection classes were attended at the rates of 61 percent and 54 percent respectively. Seven employees of the 388 scheduled to attend the Disciplinary Decision Making System (DDMS)/Ward Grievance training were reported as attending.

Several mandated annual training classes were listed but the attendance was lower than would be expected. For example:

- Only 3 people attended side handle baton training but the team observed several officers carrying the baton.
- Twenty-four staff members attended the Effective Interaction class.
- Fifty-one staff attended the Fire/Safety class.
- Four employees attended the workplace violence training.
- Forty-six employees attended the Emergency Preparedness training.
- Two hundred and thirty six staff attended the mandated suicide prevention training.
- Although not mandated, four employees attended the Signs and Symptoms of Mental Illness class.
- There was no documentation of anyone attending the mandated sexual harassment training.

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.

Finding: Training for Medical Technical Assistants (MTA) was not included in this review.

Discussion: The training coordinator reported that all training for MTAs was recorded through the Central Division and she had no record of the classes attended by them. MTAs are required to meet all of the mandated training requirements for other officers. The team was unable to determine what percentage of the MTA classification had received training.

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 directing supplemental supervision training. All supervisors and managers are required to attend the initial management/supervision peace officer training however no updates are scheduled. Instead, it is up to the facility management to decide appropriate and necessary training to develop current and future.

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. The orientation is being performed for custody officers but facility management was not aware of it being completed for non-custody staff.

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 peace officers.

Discussion: The team asked if a "field training" program was in place to train new recruits. Supervisors and managers interviewed said the orientation provided to new employees is limited to the 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 NACYCF 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 (DWNCF, and OHCF). 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 of CDCR, 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, the 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: Protective clothing and face shields could reduce the potential for injury from gassing.

Discussion: Gassings expose the victim to infectious diseases. To be effective, a portal of entry or at least contact with the skin of the victim is needed. Protective clothing such as long sleeved upper body clothing or jumpsuits would reduce the potential for contact with the skin or open sores of the victim. Clear face shields would reduce the potential for contact with eyes, ears, nose and mouth of the victim. The face shields could incorporate a hair covering. Protective gloves could protect the victim's hands. While maybe uncomfortable to wear, the team suggested consideration be given to making the protective clothing available to staff working in the units where the incidents of assault are more frequent.

Finding: Staff report 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 be delivered 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: 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. As a result of the most recent staff assault, a device was added to the Pajaro Hall to aid in the FM alarm reception. This device uses an antenna that is accessible to the wards. Staff must continually check this antenna to ensure wards have not tampered with it. 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: There are no procedures in place to address the use of the 37-millimeter gas guns maintained in the unit control booth on Unit I and in the school control booth.

Discussion: Without a detailed procedure for the use of the 37-millimeter gas guns, staff is unaware of the situations in which these weapons should be used. Additionally, without a procedure directing staff on the proper method of deployment this weapon could be accidentally discharged striking a staff or a non-involved ward.

Finding: Officers are provided safety equipment as specified by policy.

Discussion: Each officer is issued handcuffs, OC/Mace spray and latex gloves. Advantage 1000 respirators are available in all living units, security vehicles and are issued to individual staff assigned to special teams. Tactical team members and those staff having received the initial training are issued batons. A "911 Rescue Tool", a tool used to cut a suicide ligature, is available in all living units. CPR masks are available in the housing units and security vehicles.

Finding: Stab vests have been issued to the peace officers assigned to Kern and Sacramento Halls.

Discussion: Only the officers assigned to the tactical team and two housing units (Sacramento and Kern) are issued soft body armor stab resistant vests. The vests are assigned according to general size and are not fitted to the individual officer. A supply of older "turtle shell" vests is stored in the Sacramento and Kern Halls 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 showed 30 stab vests available for use or assigned to staff. Two of the vests were manufactured in 1998 and 1999 and one was issued to a peace officer. The other was a "pool" vest for visitors to use. The remainder were older "turtle shell" vests used for visitors. These vests were typically manufactured before 1998 and should be replaced. 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.

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 they 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.

STAFF INTERVIEWS

Interview Process

The Staff Safety Evaluation Team conducted random interviews with custody staff, Intensive Treatment Program staff, and non-custody staff at the N.A. Chaderjian Youth Correctional Facility (NACYCF) from Monday, August 8 through Thursday, August 18. 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 as Attachment D.

The Staff Safety Evaluation Team conducted random interviews with NACYCF staff, on the first, second, and third watches at the following halls: Unit I (Sacramento and Kern Halls), Unit II (Merced and McCloud Halls), Unit III (Feather and Mojave Halls), Unit IV (American and Smith Halls), Unit V (Owens and Parajo Halls), and Unit VI (San Joaquin and Tuolumne Halls). Staff was also interviewed at administration, communications center, gymnasium, and the education center. Custody staff classifications interviewed included: the Acting Superintendent, Program Administrator, the Major, Parole Agent III, Lieutenants, Sergeants, Correctional Officers, and Medical Technical Assistant. The Intensive Treatment Program included: Treatment Team Supervisors, Parole Agent I, Senior Youth Correctional Counselors, Case Work Specialists, and Youth Correctional Counselors. Non-custody staff interviewed included: the medical physician, psychologists, psychiatrists, supervising registered nurse, registered nurses, vice principal, teachers, cook, office technician, and warehouse staff.

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 and Intensive Treatment Programs, and non-custody staff.

Custody Staff - Interview with Managers

The interview team met with the Acting Superintendent, Major, Program Administrator and the Parole Agent III from August 8-18, 2005. The following findings are the result of those interviews.

Finding: Entrenched gang members direct retaliatory assaults against staff.

Discussion: The managers said that one of the most serious staff safety issues is the blatant entrenched gang presence at the institution. The team was informed that gang members have openly threatened staff by telling them that they will be retaliated against for interfering with gang activity. In one instance, gang members discovered how to provide power to electrical outlets in the cell rooms. Gang members then began selling the power to other wards. This continued until a staff member inadvertently found that the wards had electrical current in their rooms. He made this discovery when he received an electrical shock as he opened a cell door. After the electrical power was interrupted, gang members committed a staff assault in retaliation. Managers said that approximately 100 wards are deeply rooted and indoctrinated in the gang culture at NACYCF.

Managers said if deeply entrenched gang members could be removed from regular programs for a temporary period (60 to 90 days), staff could work with them in an intensive treatment program to root out those wards who wish to drop out of the gang. These wards could then be reintegrated into a regular program. Gang members that refuse to program could be moved to the Special Management Program.

Finding: The segregation of rival gangs has led to empowering the strongest gang at the facility.

Discussion: Some managers voiced their concern about how rival gang members have been segregated to prevent gang warfare at NACYCF. Historically, rival gang members were housed together in a balanced setting (equal number of rival gang members). The purpose of this balance was to promote an environment where rival gangs could coexist, and to not limit where wards could be housed (i.e. special housing for gang members only).

Over the years, events have occurred that changed this balance structure. An incident occurred at NACYCF where rival Hispanic gangs fought with each other on the recreation yard. This event was so significant that one rival gang was transferred in mass from NACYCF to a southern youth correctional facility. More recent events have further eroded the mixing of rival gang members, and the units now house gang members that can coexist with each other. This segregation has allowed the gang with the greatest numbers and influence to establish itself as the dominant structure at NACYCF. Some managers believe this is also one of the principle reasons why staff assaults have increased.

Finding: Gang entrenched wards “game” the system, allowing them to control their environment.

Discussion: Managers said that many of the documented gang members would violate the institution rules, so they can have their sentences “maxed out”, so they can avoid being placed on parole once their sentence is completed. Once a ward is “maxed out”, they become problematic to staff, as they will say to staff, “what are you going to do me? I am maxed out”. They said this attitude is particularly prevalent for wards assigned to the Special Management Program (SMP).

Gang members will also commit staff assaults, knowing they will be sent to state prison for their new offense. The ward knows they will only receive a two-year sentence for the staff assault and they will only serve eighteen months of the sentence. They also know that the sentence will run concurrent with their committed offense to the DJJ. The ward is aware that Welfare and Institutions Code Section 1732.8 (see Attachment F) allows them the right to choose if they want to return to the Youth Authority to complete their committing sentence at the Youth Authority or remain at state prison.

Managers gave the following example. They said a gang member committed a staff assault at NACYCF, and was sent to state prison on the new offense. This ward completed eighteen months of his sentence and chose to return to the DJJ. Since NACYCF is the only Northern Facility designed to house serious offenders in general population, the ward was returned to the facility where he committed his offense. When this gang member was housed in the orientation hall, he began to recruit and orient new gang members. Staff recognized this behavior, but due

to the DDMS and temporary detention restrictions, this ward remained on the dorm until he could be transferred from the institution.

Finding: Lack of adequate resources (personnel, equipment, and building maintenance) has compromised staff safety.

Discussion: Managers said they operate in crisis mode on a day-to-day basis. Staffing the facility requires inverse seniority overtime every day of the year. Managers informed the team that numerous memorandums have been forwarded up the chain of command regarding the facility's need for additional resources. There is no preventative maintenance plan; therefore, there are toilets, showers, sinks, security locks, security control panels, and personal alarm systems that require daily repair (see Physical Plant section for additional details).

NACYCF management has attempted to secure needed resources:

- A memorandum dated March 14, 2005 (copies of these memorandums are available upon request from the Superintendent's Office) requested additional positions (security, treatment, and education) to support the Open Program Model.
- A March 4, 2005 memorandum stated, "NACYCF does not have adequate radios to meet safety needs."
- A January 19, 2005 memorandum requested additional resources to address critical needs with the increase in workload demand (treatment and operations).
- An October 19, 2004 memorandum identified unfunded budget items, including: SMP school security coverage, five minute suicide prevention watch, training, posting at the outpatient hospital unit (OHU), SYCC and GIC meetings, resources to support the parole violators, and additional security coverage for problem areas.
- An October 15, 2004 memorandum requested that the recreation fence and the Special Programming Area (SPA) mesh screens be upgraded to prevent wards from breaching the fences to assault other wards or staff.

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: NACYCF has 222 custody positions, and 51 were vacant or otherwise unavailable for duty as of August 15, 2005. This accounts for a vacancy rate of 22% for peace officer positions. The group said that 300 eight-hour shifts of voluntary overtime are required every month due to vacant positions. 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 "inversed" or held over on mandatory overtime to fill up to 400 eight hour shifts of unscheduled vacant shifts. As a result, staff moral is low.

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

Discussion: The managers also said that a permanent intermittent employee (PIE) would usually replace a regular staff vacancy. While minimum staff needs are met, the program is impacted

because the intermittent employee 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 adequately manage the facility. Currently, there is no Assistant Superintendent assigned to help the Acting Superintendent and the second Program Administrator position is vacant. There is no funding 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, scheduled staff meetings would 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 8-18, 2005. The following findings are a result of those interviews.

Finding: Security and Escort (S&E) officers indicated that they do not have tactical vests available to them.

Discussion: These officers are the first responders to a facility emergency. They respond in their assigned vehicle, which are equipped with a 37mm launcher, pepper launchers, beanbags, sting balls, shields, face and gas masks to an alarm call or a radio transmission for assistance. They frequently enter a hall where violence is occurring, and their role is to intervene to restore facility security. Supervisors said officers assigned to Security and Escort should be issued tactical vests, as part of their daily uniform.

Finding: Instead of remaining in the Communications Center to direct, the watch commander responds to emergency situations and direct operations.

Discussion: Staff said that the watch commander should remain in the communications center to direct resources, provide emergency notifications, and provide command leadership in emergency situations. They agreed that the sergeant should respond to these situations and direct staff. Staff indicated that at the Heman G. Stark Youth Correctional Facility, the sergeant responds to emergencies and the watch commander remains in the control center. Though other facilities have the watch commander respond and the sergeant remains in charge of the communication or control center, supervisors were in favor of the Heman G. Stark model.

Finding: The current staffing for general population units needs to be increased due to the violence and increased occurrence of staff assaults.

Discussion: Supervisors said the current staffing pattern in general population halls require one Youth Correctional Officer in the tower (except Units I, III, IV, and V, which have a YCC

assigned to tower duty), and two Youth Correctional Counselors on each unit hall. Supervisors said the YCCs should be removed from the towers and replaced with YCOs. Due to the increased number of assaults orchestrated by gang members, they would like to see staff increased to three posted positions on the floor for each hall. With the “Open Program Model”, a staff member could be left alone on the floor with up to 50 wards out of their rooms. When this occurs, staff cannot conduct small group counseling sessions until a second staff returns to the hall.

Interviews with Line Staff

The interview team conducted random interviews with line staff from August 8-18, 2005. The following findings are the result of those interviews.

Finding: Line staff concurred with the manager and the supervisors that there is a need for additional staff.

Discussion: All line staff voiced the same concerns as the supervisors, as it related to the need for additional staff. Line staff agreed that an additional staff member is needed in Units III, IV, V and VI. They said by adding an additional Youth Correctional Counselor, the level of treatment and counseling services for wards would improve.

The presence of an additional staff member would also decrease response time, when they are designated as a member of the Emergency Response Team (ERT). Currently, when an emergency occurs, floor staff assigned to the living unit must secure the wards in their rooms prior to responding to the location of a staff alarm. This can result in a two to five minute delay in response, if the designated ERT staff is assigned to a floor position.

Finding: Line staff are concerned about their safety because of the intermittent efficiency of their personal alarms.

Discussion: The interview team asked line staff to describe the safety equipment issued to them. They responded that they are issued: personal alarms, radios in designated positions, handcuffs, OC spray, and/or CN gas. They do not turn in their OC spray or CN gas at the end of shift. They keep it in their personal possession or store it on site in a designated locker.

Line staff reported that the activation of the FM alarm system is intermittent, and the hand held radios and batteries require constant changing throughout the shift assignment.

All line staff assigned to Unit I report that they have a vest assigned to them per Bargaining Unit 6, Memorandum of Understanding Section 7.05 I 1. Staff interviewed said the vests are adequate for the job, but they would like the vest panels replaced or upgraded as recommended by the manufacturer, usually every five years.

Staff assigned to Smith, Owens, Pajaro, and San Joaquin Halls, said they would like to have access to a protective vest, especially when the tension is high.

Finding: Line staff would like 37/40 mm munitions delivery systems available as a use of force option on the units due to the perceived effectiveness of the system.

Discussion: Currently, 37mm gas launchers are carried in the Security and Escort vans and available when they are dispatched to a disturbance. Line staff would like to see the training for these devices expanded, so that the use is not limited to Security Escort positions.

Finding: Line staff would like to receive hands on training that is meaningful for their daily assignment.

Discussion: Line staff said they would like to receive training that they can apply in their post assignment on a daily basis. Specifically, training in the use and retention of the side handle baton and self-defense techniques for emergency response purposes. One staff cited the Bargaining Unit 6, Memorandum of Understanding Section 7.05 G 2 b indicates that all YCO personnel shall be issued a side handle baton and that only the Security and Escort and school security YCOs have the item assigned to their post.

Finding: Line staff believe that the “Open Program” rewards wards assigned to Unit I for disciplinary action.

Discussion: Staff said wards assigned to Unit I (Special Management Program) have additional program incentives (access to Game Boys and three hours of recreation time). They said that wards assigned to the general population living units are aware of extra privileges provided to the wards on Unit I and may exhibit poor behavior to receive DDMS write-ups. There should be greater incentives for wards to program and remain on a GP living unit.

Finding: Staff says the Disciplinary Decision Making System (DDMS) is cumbersome, and the wards are not deterred by the consequences.

Discussion: Staff indicated that there is little consequence for ward misbehavior. They complained that it is not unusual that a ward will receive temporary detention (TD) for a DDMS offense, and they will only serve one day or less in TD before being returned to the unit. When wards would return to the hall they openly mock counselors. Staff have refused to write up a ward for DDMS because the process to discipline is made cumbersome, by providing the ward with extraordinary due process rights before discipline can be imposed.

Finding: Line staff said they feel safer working in a program post assignment.

Discussion: Line staff said general population units are less safe than the other programs in the facility because of minimum staff levels (two staff in each hall). In an emergency situation, there is more staff available on the program hall and the adjacent sister hall.

Interviews with Treatment Programs

The first and second line supervisors Senior Youth Correctional Counselor (SYCC) and Treatment Team Supervisor (TTS) were interviewed at various work locations from August 8 – 18. The following findings are the result of those interviews.

Finding: Staff said that Unit I (Kern and Sacramento Halls) is the only living unit, which requires staff to wear protective vests while performing their duties.

Discussion: They reported that an inadequate number of vests are available on the unit, especially if staff other than posted positions are on the floor. A second concern is that the covers for the vests are not regularly laundered or maintained in a sanitary condition for staff use.

Finding: Staff assaults have reduced the availability of regular staff who facilitate some of the treatment programs.

Discussion: The TTS said staff assaults have reduced the availability of his treatment team. He said as a result, there is a lack of consistency in the facilitation of the ward program due to changes in personnel on a shift-to-shift basis. He said, the six post staffing pattern would be beneficial, but staff assigned to the treatment programs need additional training. He said staff would benefit from training in the areas of identifying the gang structures experienced at NACYCF, soliciting a commitment from the ward population to participate in positive and productive programming services, and the supervision and control of their assigned living unit population.

SUMMARY AND CONCLUSION

N.A. Chaderjian Youth Correctional Facility (NACYCF) was the fourth Division of Juvenile Justice (DJJ) facility to be evaluated by the Staff Safety Evaluation Team, and immediately followed the evaluations of the O.H. Close (OHCYCF) and DeWitt Nelson Youth Correctional Facilities (DWNYCF). 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 DWNYCF 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 previous DJJ facility reports, it has become 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 in previous evaluations 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. Wards exhibiting bad behavior often become leaders among the ward population. Bad behavior becomes a prestige symbol and/or is used to pressure others to misbehave. Unfortunately, bad behavior by a few wards jeopardizes the success of programs for those wards otherwise willing to participate.

It must be recognized that many of the wards in the DJJ system are adults who 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. Lack of a discipline system is a disservice to the wards as they are not being prepared to re-enter the community where they will experience consequences for their misdeeds.

There have been suggestions that NACYCF should be closed in favor of housing wards in dorm housing as opposed to the single occupancy rooms at NACYCF. The evaluation team believes that the single room configuration the living units at this facility are vital to the Juvenile Justice Division's ability to house the current ward population. Many of the young adult wards housed at this facility have a demonstrated history of violence. Housing these wards in an open dorm setting would place staff and other wards in harm's way. Maintaining a facility comprised of single room housing units is paramount for the safety of the wards and the staff supervising the wards.

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



July 19, 2005

Eric Umeda, Superintendent (A)
N. A. Chaderjian Youth Correctional Facility
7650 S. Newcastle Road
Stockton, CA 95213-9014,

Dear Superintendent Umeda:

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 O.H. Close and DeWitt Nelson 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 N.A. Chaderjian 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

NACYCF STAFF ASSAULT DATA January 2004 through June 2005

INCIDENT INFORMATION					INMATE/WARD INFORMATION									
Date	Time	Day of Week	Site and Location	Type of Assault	Serious Injury	Inmate Weapon	IM#/YA#	Ethnicity	Classification	Rec'd CYA	Rec'd Inst	Anticipated Rel Date/PBD	Age	Housing Loc @ time of assault
1/13/2004	1145	Tuesday	Kern	Yellowish liquid substance thrown at staff	No	No	86365	Filipino	SMP	7/24/2001	6/12/2003	1/1/2005	20	Kern
1/20/2004	1151	Tuesday	Pajaro	Ward struck staff in face	Yes	Battery	84131	Hispanic	General	4/18/2002	2/4/2004	4/1/2006	22	Pajaro
1/20/2004	1151	Tuesday	Pajaro	Ward attacked staff	Yes	Battery	86245	White	General	6/27/2001	3/30/2004	5/1/2004	21	Smith
2/2/2004	1023	Monday	Sacramento	Unknown liquid substance squirted @ staf	No	Ukn liquid	86365	Filipino	SMP	7/24/2001	6/12/2003	1/1/2005	20	Sacramento
3/30/2004	1920	Tuesday	Kern	Unknown liquid substance thrown at staff	No	Ukn liquid	82445	Afr. American	SMP	6/2/1999	4/25/2005	9/1/2006	20	Sacramento
4/5/2004	2053	Monday	Owens	Ward struck staff's facial and upper body	Yes	Hands	85084	Hispanic	General	10/10/2000	6/30/2003	9/1/2002	20	Owens
4/5/2004	2053	Monday	Owens	Ward struck staff's facial and upper body	Yes	Hands	86848	Hispanic	General	11/19/2001	11/10/2003	4/3/2006	19	Owens
4/8/2004	1625	Thursday	Kern	Unknown liquid thrown at staff's back	No	Ukn liquid	82445	Afr. American	SMP	6/2/1999	4/25/2005	9/1/2006	20	Sacramento
5/1/2004	1340	Saturday	Sacramento	Unknown liquid thrown at staff's face	No	Ukn liquid	85661	Hispanic	SMP	2/8/2001	9/11/2003	12/1/2005	19	Sacramento
5/3/2004	1554	Monday	Merced	Spit on staff's face	No	Blood	88947	Hispanic	ITP	7/9/2003	10/7/2003	6/1/2005	19	Merced
5/17/2004	1120	Monday	Sacramento	Staff struck w/ container filled with food	No	Container	77913	Afr. American	General	3/31/1997	12/16/2003	7/1/2005	24	Smith
5/23/2004	1328	Sunday	Owens	Spit on staff, making skin contact	No	Saliva	83632	Afr. American	General	12/28/1999	3/11/2005	5/1/2006	20	Owens
5/23/2004	1328	Sunday	Owens	Spit on staff, making skin contact	No	Saliva	83632	Afr. American	General	12/28/1999	3/11/2005	5/1/2006	20	Owens
5/23/2004	1328	Sunday	Owens	Spit on staff, making skin contact	No	Saliva	83632	Afr. American	General	12/28/1999	3/11/2005	5/1/2006	20	Owens
5/25/2004	1835	Tuesday	Kern	Wrist/arm pulled through IRA port/twisted	Yes	Battery	86476	Afr. American	SMP	8/16/2001	10/9/2003	2/1/2006	20	Kern
6/9/2004	2012	Wednes.	Merced	Spit on staff, making skin contact	No	Saliva	86261	White	ITP	7/12/2001	1/28/2004	3/1/2006	20	Merced
7/12/2004	1055	Monday	Kern	Staff "slashed" (hand) prison made weapo	Yes	metal spring	87618	Hispanic	General	6/19/2002	5/24/2004	8/1/2005	20	Kern
7/16/2004	1110	Friday	Sacramento	Spit on staff (eyes, mouth, nose)	No	Saliva	77913	Afr. American	General	3/31/1997	12/16/2003	7/1/2005	24	Sacramento
7/27/2004	1815	Tuesday	Kern	Spitting on staff	No	Saliva	85661	Hispanic	General	2/8/2001	9/11/2003	12/1/2005	19	Kern
8/4/2004	1007	Wednes.	McCloud/Class	Struck w/fist (back, upper left torso)	No	Battery	88812	Hispanic	SCP	6/17/2004	6/17/2004	12/1/2005	19	McCloud
8/10/2004	1245	Tuesday	Merced	Unknown liquid substance thrown at staff	No	Ukn liquid	86261	White	ITP	7/12/2001	1/28/2004	3/1/2006	20	Merced
8/11/2004	1044	Wednes.	Merced	Unknown liquid substance thrown at staff	No	Ukn liquid	86261	White	ITP	7/12/2001	1/28/2004	3/1/06	20	Merced
8/12/2004	1600	Thursday	Kern	Spitting on staff	No	Saliva	82458	Hispanic	SMP	6/8/1999	8/13/2001	9/1/2006	22	Kern
8/13/2004	1050	Friday	Sacramento	Unknown liquid substance thrown at staff	No	Ukn liquid	88047	Afr. American	SMP	9/27/2002	10/22/2003	12/1/2005	19	Sacramento
8/19/2004	1625	Thursday	Kern	Staff hit w/fist & handcuffs (head & neck)	Yes	Battery	82666	Afr. American	SMP	7/8/1999	6/4/2003	2/1/2008	20	Kern
8/24/2004	1345	Tuesday	Sacramento	Spitting on staff	No	Saliva	88758	Afr. American	SMP	9/19/2003	9/19/2003	9/1/2005	18	Sacramento
8/24/2004	1435	Tuesday	Sacramento	Spitting on staff	No	Saliva	88758	Afr. American	SMP	9/19/2003	9/19/2003	9/1/2005	18	Sacramento
8/24/2004	1640	Tuesday	Sacramento	Staff was kicked/ran into by ward	Yes	Battery	88758	Afr. American	SMP	9/19/2003	9/19/2003	9/1/2005	18	Sacramento
8/30/2004	1045	Monday	Kern	Spitting on staff	No	Saliva	88758	Afr. American	SMP	9/19/2003	9/19/2003	9/1/2005	18	Kern
9/11/2004	1740	Saturday	Pajaro	Hit w/closed fist (lower right cheek/lip)	No	Battery	84779	Hispanic	General	9/13/2001	5/13/2004	11/1/2006	20	Pajaro

NACYCF STAFF ASSAULT DATA January 2004 through June 2005

INCIDENT INFORMATION					INMATE/WARD INFORMATION									
10/2/2004	1258	Saturday	Sacramento	Spitting on staff (facial area)	No	Saliva	87618	Hispanic	SMP	6/19/2002	5/24/2004	8/1/2005	20	Sacramento
10/4/2004	1210	Monday	Pajaro	Struck w/fists (torso/facial area knocked down)	Yes	Battery	89249	Hispanic	General	10/8/2003	5/21/2004	1/1/2006	20	Pajaro
10/14/2004	2205	Thursday	Kern	Unknown liquid substance thrown at staff	No	Ukn liquid	89356	Afr. American	General	12/4/2003	3/23/2004	3/1/2006	19	Kern
10/18/2004	2010	Monday	Kern	Unknown liquid substance thrown at staff	No	Ukn liquid	86954	White	SMP	12/18/2001	10/26/2004	4/1/2005	21	Kern
10/20/2004	1005	Wednes.	Kern	Unknown liquid substance thrown at staff	No	Ukn liquid	89641	Afr. American	General	2/9/2004	3/11/2004	6/29/2006	19	Kern
10/20/2004	1005	Wednes.	Kern	Unknown liquid substance thrown at staff	No	Ukn liquid	89641	Afr. American	General	2/9/2004	3/11/2004	6/29/2006	19	Kern
11/3/2004	852	Wednes.	School Area	Struck w/closed fists (head/body area)	Yes	Battery	79597	Afr. American	General	1/27/1998	2/3/2004	9/1/2006	23	Owens
11/4/2004	1230	Thursday	Kern	Spitting on staff	No	Saliva	89319	White	SMP	11/6/2003	9/9/2004	10/1/2007	19	Kern
11/4/2004	1230	Thursday	Kern	Spitting on staff	No	Saliva	89319	White	SMP	11/6/2003	9/9/2004	10/1/2007	19	Kern
11/16/2004	1520	Tuesday	Kern	Staff kicked (on leg, below knee)	Yes	Battery	89586	White	SMP	1/26/2004	10/27/2004	11/1/2005	18	Kern
11/16/2004	1520	Tuesday	Kern	Staff kicked (thigh & forearm)	No	Battery	89586	White	SMP	1/26/2004	10/27/2004	11/1/2005	18	Kern
12/1/2004	2125	Wednes.	Kern	Struck in the chest	No	Battery	87054	White	General	1/22/2002	10/24/2002	12/1/2004	21	Kern
12/21/2004	835	Tuesday	San Joaquin	Struck in head/upper body with closed fists	Yes	Battery	87620	Afr. American	General	6/11/2002	10/8/2003	8/1/2006	21	San Joaquin
12/21/2004	835	Tuesday	San Joaquin	Struck in head/upper body with closed fists	Yes	Battery	88242	Afr. American	General	11/26/2002	4/21/2004	7/1/2005	19	San Joaquin
12/24/2004	1815	Friday	Sacramento	Unknown liquid substance thrown at staff	No	Ukn liquid	89632	Afr. American	General	2/18/2004	2/22/2005	4/1/2006	18	Sacramento
1/6/2005	1155	Thursday	Smith	Unknown liquid substance thrown at staff	No	Ukn liquid	88135	Afr. American	General	10/24/2002	11/4/2004	11/1/2005	19	Sacramento
1/6/2005	1155	Thursday	Smith	Unknown liquid substance thrown at staff	No	Ukn liquid	88135	Afr. American	General	10/24/02	11/4/2004	11/1/2005	19	Smith
1/14/2005	1900	Friday	Kern	Unknown liquid substance thrown at staff	No	Ukn liquid	87622	Afr. American	General	6/13/2002	11/23/2004	8/1/2005	20	Smith
1/19/2005	725	Wednes.	Owens	Struck in head/face area	Yes	Battery	85021	Hispanic	General	9/26/2000	8/5/2004	2/1/2006	20	Owens
1/20/2005	1030	Thursday	Sacramento	Unknown liquid substance thrown at staff	No	Ukn liquid	88064	Hispanic	General	10/20/2002	1/21/2004	1/1/2007	19	Sacto
2/2/2005	836	Wednes.	Pajaro	Struck w/fists, left side head/neck	Yes	Battery	82957	Afr. American	General	6/22/2001	8/19/2004	5/1/2005	20	Pajaro
2/2/2005	836	Wednes.	Pajaro	Struck w/fists, left side face	Yes	Battery	82957	Afr. American	General	6/22/2001	8/19/2004	5/1/2005	20	Pajaro
3/8/2005	1515	Tuesday	Kern	Unknown liquid substance thrown at staff	No	Ukn liquid	88282	Afr. American	SMP	12/16/2002	9/23/2004	11/1/2005	19	Kern
3/16/2005	630	Wednes.	San Joaquin	Struck w/fists to head/face area	Yes	Battery	89879	Hispanic	General	5/18/2004	11/5/2004	3/1/2006	18	San Joaquin
4/4/2005	2125	Monday	American	Spitting on staff (face/eye)	No	Saliva	86637	White	General	9/26/2001	4/1/2005	9/1/2005	21	American
4/13/2005	1440	Wednes.	Owens	Struck w/fists head/neck area	Yes	Battery	89150	Afr. American	General	9/4/2003	8/26/2004	4/1/2006	19	Owens
4/13/2005	1440	Wednes.	Owens	Pushed/hit from behind	Yes	Battery	unidentified	-	-	-	-	-	-	-
4/17/2005	1717	Sunday	Pajaro	Struck w/fists head/facial area	Yes	Battery	85794	Hispanic	General	4/17/2001	10/5/2004	7/1/2006	18	Pajaro
4/25/2005	1215	Monday	Kern	Unknown liquid substance thrown at staff	No	Ukn liquid	88856	Afr. American	General	6/3/2003	3/29/2005	6/1/2006	18	San Joaquin
4/25/2005	1620	Monday	Kern	Unknown yellow substance thrown (face, mouth)	No	Ukn liquid	88856	Afr. American	General	6/3/2003	3/29/2005	6/1/2006	18	Kern

NACYCF STAFF ASSAULT DATA
January 2004 through June 2005

INCIDENT INFORMATION					INMATE/WARD INFORMATION										
4/30/2005	1220	Saturday	Receiving	Struck w/fist in face, multiple times	Yes	Battery	85794	Hispanic	General	4/17/2001	10/5/2004	7/1/2006	18	Kern	
5/3/2005	1910	Tuesday	San Joaquin	Struck w/fist head/facial area multiple x's	Yes	Battery	88562	Afr. American	General	3/4/2003	5/13/2004	1/1/2006	19	San Joaquin	
5/5/2005	1155	Thursday	Kern	Unknown liquid substance thrown at staff	No	Ukn liquid	88766	White	SMP	6/5/2003	10/18/2004	7/1/2005	18	Kern	
5/27/2005	1820	Friday	Merced	Unknown liquid substance thrown at staff	No	Ukn liquid	86348	Hispanic	ITP	7/31/2001	6/1/2004	2/1/2006	20	Merced	
5/30/2005	1705	Monday	Sacramento	Unknown liquid substance thrown at staff	No	Ukn liquid	87826	Afr. American	SMP	8/15/2002	9/9/2004	9/1/2005	18	Sacramento	
5/31/2005	1639	Tuesday	Sacramento	Unknown liquid substance thrown at staff	No	Ukn liquid	86586	Afr. American	General	12/1/2004	12/1/2004	10/1/2007	18	Pajaro	
5/31/2005	1553	Tuesday	Sacramento	Struck w/fist left side of head/ear	Yes	Battery	85096	Afr. American	SMP	10/18/2000	12/16/2003	2/1/2007	20	Sacramento	
6/10/2005	702	Friday	Sacramento	Struck w/fist, left side jaw	Yes	Battery	84730	Hispanic	SMP	7/31/2000	12/5/2003	12/1/2006	19	Sacramento	
6/21/2005	928	Tuesday	Sacramento	Unknown liquid substance thrown at staff	No	Ukn liquid	88018	Hispanic	SMP	10/2/2002	7/6/2004	4/1/2006	20	Sacramento	
6/21/2005	928	Tuesday	Sacramento	Unknown liquid substance thrown at staff	No	Ukn liquid	88018	Hispanic	SMP	10/2/2002	7/6/2004	4/1/2006	20	Sacramento	
6/21/2005	928	Tuesday	Sacramento	Unknown liquid substance thrown at staff	No	Ukn liquid	88018	Hispanic	SMP	10/2/2002	7/6/2004	4/1/2006	20	Sacramento	
6/21/2005	928	Tuesday	Sacramento	Unknown liquid substance thrown at staff	No	Ukn liquid	88018	Hispanic	SMP	10/2/2002	7/6/2004	4/1/2006	20	Sacramento	
6/21/2005	928	Tuesday	Sacramento	Unknown liquid substance thrown at staff	No	Ukn liquid	88018	Hispanic	SMP	10/2/2002	7/3/2004	4/1/2006	20	Sacramento	
6/26/2005	1638	Sunday	Kern	Unknown liquid substance thrown at staff	No	Ukn liquid	86586	Afr. American	SMP	12/1/2004	12/1/2004	10/1/2007	18	Kern	
7/6/2005	1803	Wednes.	Pajaro	Struck w/fists, kicked in head/body area	Yes	Battery	87417	Hispanic	General	4/24/2002	3/25/2005	7/1/2006	21	Pajaro	
7/6/2005	1803	Wednes.	Pajaro	Struck w/fists, kicked in head/body area	Yes	Battery	90110	Hispanic	General	8/11/2004	12/1/2004	6/1/2006	18	Pajaro	
7/6/2005	1803	Wednes.	Pajaro	Struck w/fists	Yes	Battery	87417	Hispanic	General	4/24/2002	3/25/2005	7/1/2006	21	Pajaro	
7/6/2005	1803	Wednes.	Pajaro	Struck w/fists	Yes	Battery	90110	Hispanic	General	8/11/2004	12/1/2004	6/1/2006	18	Pajaro	
7/6/2005	1803	Wednes.	Pajaro	Struck w/fists	Yes	Battery	80689	Hispanic	General	8/4/1998	4/13/2005	1/1/2006	24	Pajaro	
7/6/2005	1803	Wednes.	Pajaro	Struck w/fists	Yes	Battery	90110	Hispanic	General	8/11/2004	12/1/2004	6/1/2006	18	Pajaro	
7/11/2005	1108	Monday	Kern	Sexual Battery	No	Hand	87096	Afr. American	General	2/14/2002	10/8/2003	7/1/2006	20	Kern	
7/15/2005	1510	Friday	Kern	Struck, upper lefts side/shoulder area	No	Battery	85169	Hispanic	SMP	10/25/2000	3/25/2005	12/1/2002	21	Kern	
7/16/2005	1645	Saturday	Owens	Struck w/fists	Yes	Battery	84865	Hispanic	General	10/31/2002	6/22/2004	3/1/2006	20	Owens	
7/17/2005	1331	Sunday	Kern	Unknown liquid substance (face/head/arm)	No	Ukn liquid	90060	Hispanic	General	8/3/2004	3/2/2005	5/1/2007	18	Kern	
7/17/2005	1155	Sunday	San Joaquin	Unknown liquid substance (face/head/arm)	No	Ukn liquid	88324	White	General	1/9/2003	4/12/2005	5/1/2006	18	San Joaquin	
7/20/2005	2007	Wednes.	Sacramento	Clear liquid substance thrown on staff	No	Ukn liquid	86352	Afr. American	SMP	7/26/2001	4/4/2005	10/1/2006	18	Sacramento	
7/19/2005	1100	Tuesday	Kern	Struck w/fist, right side of face	Yes	Battery	88324	White	General	1/9/2003	4/12/2005	5/1/2006	18	Kern	
7/19/2005	1940	Tuesday	Kern	Kicked on left knee	Yes	Battery	90060	Hispanic	General	8/3/2004	3/2/2005	5/1/2007	18	Kern	
7/21/2005	1045	Thursday	Sacramento	Unknown liquid substance thrown at staff	No	Ukn liquid	86352	Afr. American	SMP	7/26/2001	4/4/2005	10/1/2006	18	Sacramento	

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

FACILITY: N. A. Chaderjian Youth Correctional Facility	TYPE:	DATE: 8-8-05
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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
Kern	Single	1	50	50	0	32	Temporary Detention Unit.	2	4	4
Sacramento	Single	1	50	50	0	42	Special Management Program.	2	4	4
Merced	Single	1	50	50	0	38	ITP.	2	4	4
Mc Cloud	Single	1	50	50	0	35	General population.	1	2	3
Feather	Single	1	50	50	0	49	Sex offender program.	1	2	2
Mojave	Single	1	50	50	0	53	Orientation/General population.	1	2	2
American	Single	1	50	50	0	42	Protective custody.	1	2	2
Smith	Single	1	50	50	0	39	General Population including Bull Dogs.	1	2	2
Owens	Single	1	50	50	0	41	General population.	1	2	2
Pajaro	Single	1	50	50	0	29	General population.	1	2	2
San Joaquin	Single	1	50	50	0	25	General population.	1	2	2
Tuolumne	Single	1	50	50	0	56	Drug treatment program.	1	2	2
Security and Escort								3	3	3

**N.A. Chaderjian Youth Correctional Facility
August 8 – 18, 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. What most would you like to do or see changed to improve staff safety?
15. How often do you see and/or speak with your supervisor? Your supervisor's supervisor? The superintendent?
16. Are protocols in place for emergency responses?
17. (Policy?)What happens when a staff member is assaulted? If the staff person is injured, where do they go for first aid or for emergency treatment in more serious cases? How long might that take? Who investigates? Are criminal charges filed?

Supervisors:

1. How long have you been assigned to this facility as a supervisor?
2. How many years do you have as a supervisor?
3. Have you worked as a supervisor at any other CYA institution?
4. Describe your duties and responsibilities, and how you carry them out during a routine shift.
5. How many staff do you directly supervise?
6. How many do you indirectly supervise?
7. What is the percentage of time (shift) do you spend personally observing your subordinates?
8. How often do you see your supervisors?
9. Can you describe the safety equipment that is issued to line staff?

10. Is there any other safety equipment, which you know of, available for staff's use? What is it?
11. Do you have a stab vest? Have you been fitted for one? Do you wear it at all times?
12. Does your staff have stab vests? Have they been fitted for one? Do you ensure that they wear it at all times?
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 would you like to do or see changed to improve staff safety and reduce staff assaults?
15. What do you do to ensure a safe working environment for your staff?
16. What kind of staff safety complaints do you get from staff? Are there any patterns that emerge? How do you handle them?
17. What protocols in place for emergency responses?
18. 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. Do you have any long range plans to ensure staff safety and to reduce staff assaults?
13. What kinds of staff safety complaints do you get from staff? Are there any patterns that emerge?
14. 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?
15. Have the number of vacancies, SCIF 3301, other leave of absences affected staff safety? Do you have mandated overtime for staff and supervisors?
16. 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?
17. 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?

18. What protocols in place for emergency responses?

19. 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**

Team 1

Staff Interviews:

Robert Takeshta, CSA Field Representative
John McAuliffe, Adult Operations, Correctional Counselor II
Jeff Plunkett, Division of Juvenile Justice, Captain

Team 2

Physical Plant, Staffing and Population:
Gary Wion, CSA Field Representative
Mark Perkins, Adult Operations, Facility Captain
Mark Miller, Division of Juvenile Justice, Lieutenant

Team 3

Facility Profile, Documentation Review and Data Analysis:
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Excerpt from Welfare and Institutions Code Section 1732.8

(a) Notwithstanding any other law and subject to the provisions of this section, the Director of the Youth Authority may transfer to and cause to be confined within the custody of the Director of Corrections any person 18 years of age or older who is subject to the custody, control, and discipline of the Department of the Youth Authority and who is scheduled to be returned, or has been returned, to the Department of the Youth Authority from the Department of Corrections after serving a sentence imposed pursuant to Section 1170 of the Penal Code for a felony that was committed while he or she was in the custody of the Department of the Youth Authority.

(b) No person shall be transferred pursuant to this section until and unless the person voluntarily, intelligently, and knowingly executes a written consent to the transfer, which shall be irrevocable.

(c) Prior to being returned to the Youth Authority, a person in the custody of the Department of Corrections who is scheduled to be returned to the Department of the Youth Authority shall meet personally with a Youth Authority parole agent or other appropriate Department of the Youth Authority staff member. The parole agent or staff member shall explain, using language clearly understandable to the person, all of the following matters:

- (1) What will be expected from the person when he or she returns to a Youth Authority institution in terms of cooperative daily living conduct and participation in applicable counseling, academic, vocational, work experience, or specialized programming.
- (2) The conditions of parole applicable to the person, and how those conditions will be monitored and enforced while the person is in the custody of the Youth Authority.
- (3) The person's right under this section to voluntarily and irrevocably consent to continue to be housed in an institution under the jurisdiction of the Department of Corrections instead of being returned to the Youth Authority.

(d) A person who has been returned to the Youth Authority after serving a sentence described in subdivision may be transferred to the custody of the Department of Corrections if the person consents to the transfer after having been provided with the explanations described in subdivision (c).

(e) If a Youth Authority person consents to being housed in an institution under the jurisdiction of the Department of Corrections pursuant to this section, he or she shall be subject to the general rules and regulations of the Department of Corrections. The Youth Authority Board shall continue to determine the person's eligibility for parole at the same intervals, in the same manner, and under the same standards and criteria that would be applicable if the person were confined in the Department of the Youth Authority. However, the board shall not order or recommend any treatment, education, or other programming that is unavailable in the institution where the person is housed, and shall not deny parole to a person housed in the institution based solely on the person's failure to participate in programs unavailable to the person.

(f) Any person housed in an institution under the jurisdiction of the Department of Corrections pursuant to this section who has not attained a high school diploma or its equivalent shall participate in educational or vocational programs, to the extent the appropriate programs are available.

(g) Upon notification by the Director of Corrections that the person should no longer be housed in an institution under its jurisdiction, the Department of the Youth Authority shall immediately send for, take, and receive the person back into an institution under its jurisdiction