OFFICE OF THE INSPECTOR GENERAL

MATTHEW L. CATE, INSPECTOR GENERAL

SPECIAL REVIEW INTO THE DEATH OF A WARD ON AUGUST 31, 2005 AT THE N. A. CHADERJIAN YOUTH CORRECTIONAL FACILITY

DECEMBER 2005

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EXECUTIVE SUMMARY

This report presents the results of a special review conducted by the Office of the Inspector General into the circumstances surrounding the August 31, 2005 suicide of a Ward at the N.A. Chaderjian Youth Correctional Facility (N.A. Chaderjian) in Stockton (hereinafter "the Ward"). The review was conducted pursuant to the Office of the Inspector General's responsibility under California Penal Code section 6126 for oversight of the California Department of Corrections and Rehabilitation and its subordinate entities.

The Ward, an 18-year old northern Hispanic gang member, was a resident of Pajaro Hall at N.A. Chaderjian. He was found at approximately 6:53 p.m. on August 31, 2005 hanging from the upper bunk of his single occupancy room with a bed sheet tightly fastened around his neck. He had covered the windows of his room to keep staff from observing his actions. The Ward was found not breathing and without a pulse. He was transported to San Joaquin General Hospital, where he was pronounced dead at 7:55 p.m. The coroner's report listed the cause of death as suicide.

At the time of his death, the Ward had been confined to his room for nearly 24 hours a day for eight weeks because members of his gang had violently attacked three staff members, even though the Ward did not participate in the attack. While the Ward had a history of involvement in numerous ward fights, he had no history of attacking staff. The attack prompted a lockdown of the entire facility. Although other living units gradually moved toward normal operation, the Ward and the other northern Hispanics in Pajaro Hall remained locked in their rooms while the staff tried to persuade them to renounce gang behavior in exchange for increased privileges. This resulted in a deadlock between administrators and the gang members, who were led by a powerful northern Hispanic gang member who also resided in Pajaro Hall—a ward described as a "shot caller" in the northern gang structure who had previously been identified as the "number two man" at Pleasant Valley State Prison, an adult institution. Aside from brief showers about three times per week, the Ward and the other northern Hispanics in Pajaro Hall received virtually no exercise, education, mental health treatment or other mandated services during the lockdown.

The purpose of the Office of the Inspector General's special review was to determine whether the Division of Juvenile Justice and N.A. Chaderjian followed essential policies and procedures for screening, treating, and confining the Ward before his suicide and whether the facility staff followed policies and procedures from the time they discovered that the Ward had covered the windows of his room through the time the Department of Corrections and Rehabilitation announced his death.

The Office of the Inspector General found that, although the lockdown of the facility was initially justified, the eight weeks of isolation and the denial of mental health and other services may have contributed to the Ward's suicide. The situation placed the Ward in the position of either renouncing his gang and facing violent retribution as a result, or continuing to live in what for him appeared to be increasingly intolerable conditions. The extent to which the institution deprived the Ward and the other northern Hispanic wards living in Pajaro Hall of services is also inconsistent with the mission of the Division of Juvenile Justice.

The review further determined that the Division of Juvenile Justice failed several times to properly assess and act on the Ward's mental health needs. In so doing, the division missed several signals that should have caused the Ward to be provided with mental health services. When the Ward arrived at the Preston Youth Correctional Facility, for example, that institution failed to refer him for an in-depth mental health assessment, and he was never seen by a mental health professional even though he requested four times to be seen by the mental health staff.

The Office of the Inspector General also found that 38 minutes elapsed from the time the living unit staff discovered that the Ward had covered the windows to his room and was unresponsive, until the time his door was finally opened. Although it is not possible to determine whether a faster response would have prevented the suicide, it is clear that the delay occurred because the living unit and communication center staff failed to follow appropriate policies and procedures.

In January 2005, the Office of the Inspector General recommended that the former California Youth Authority end the practice of confining wards 23 hours a day. Nonetheless, the department's successor agency, the Division of Juvenile Justice, continues to use this method to maintain order. This special review demonstrates again the dangers of the practice. The Office of the Inspector General again recommends that the Department of Corrections and Rehabilitation immediately end the practice of isolating wards in their rooms over extended periods of time.

The Office of the Inspector General also recommends that the Division of Juvenile Justice develop policies and procedures to provide a minimum level of mental health intervention during lockdowns or modified programs exceeding 14 days, and that the secretary of the Department of Corrections and Rehabilitation be required to approve in writing lockdowns or modified programs extending beyond 14 days. Additional recommendations are presented in the body of the report.

INTRODUCTION

This report presents the results of a special review conducted by the Office of the Inspector General into the circumstances surrounding the August 31, 2005 suicide of the Ward at the N.A. Chaderjian Youth Correctional Facility. The review was conducted pursuant to the Office of the Inspector General's responsibility under California Penal Code section 6126 for oversight of the California Department of Corrections and Rehabilitation and its subordinate entities. This special review was performed between September 6, 2005 and December 14, 2005.

BACKGROUND

The Ward, an 18-year old resident of Pajaro Hall in the N.A. Chaderjian Youth Correctional Facility (N.A. Chaderjian), was found at approximately 6:53 p.m. on August 31, 2005 hanging from the upper bunk in room 4, his single occupancy room. He had a bed sheet tightly secured around his neck. He had covered the windows of his room to keep staff from observing his actions. The Ward was found not breathing and without a pulse. He was transported to San Joaquin General Hospital and pronounced dead at 7:55 p.m. The coroner's report listed the cause of death as suicide.

The Ward was committed to the Division of Juvenile Justice on April 5, 2004 for vehicle theft. He was first placed at the Preston Youth Correctional Facility in Ione, California. On March 18, 2005, he transferred to N.A. Chaderjian. Division of Juvenile Justice records indicate that the Ward was a northern Hispanic gang member who exhibited strong loyalty to his gang but who was described by staff as a follower rather than a leader. The records indicate that he was involved in 15 ward-on-ward fights or group disturbances during his 11 months at Preston Youth Correctional Facility, and that he was involved in two fights during his three and one-half months at N.A. Chaderjian before he was placed in lockdown. Yet he had never assaulted staff. There is also no evidence in the records that the Ward used a weapon in any of his fights with other wards, although, in 2004 he received a behavior report for "possession, control, or manufacture of a weapon." Management staff interviewed by the Office of the Inspector General expressed concerns that the Ward's gang loyalty and description as a follower could make him dangerous because he might be encouraged by his gang leaders to carry out an assault against staff.

The Ward was five feet, five inches tall and weighed 120 pounds. When he was seven years old, his father was shot to death. His mother has a history of chronic drug abuse and addiction in addition to an extensive criminal history.

Upon his arrival at the Preston Youth Correctional Facility, the Ward was tested for suicide risk using the Division of Juvenile Justice's standard suicide risk screening questionnaire. His suicide risk was found to be low. Evidence suggests that the Ward also received a treatment needs assessment, which is designed to distinguish at-risk wards needing specific types of mental health and other treatment services. During the course of his custody with the Division of Juvenile Justice, the Ward was tested many additional times using the standard suicide risk screening questionnaire and found to be low risk each time.

N.A. Chaderjian is one of eight youth correctional facilities operated by the Division of Juvenile Justice within the California Department of Corrections and Rehabilitation. In addition to general population housing, N.A. Chaderjian has a variety of specialized programs for wards. These programs include drug and alcohol abuse treatment, intensive treatment programs, parole violator programs, special counseling programs, sex offender programs, and a special management program for violent and disruptive wards.

Wards may be referred to the special management program when a ward's behavior includes such actions as physical assaults on staff, assaults with a weapon against other wards, possession of a weapon, or acting as the aggressor in a group attack. In contrast to general population programs, which typically share a psychologist among three or four living units, the special management program has an assigned mental health professional such as a psychologist or psychiatrist. Division policy states that wards cannot be placed in the special management program beyond 90 days unless the extension is approved by the restricted program review committee. Such approvals require a face-to-face interview of a ward by a mental health professional, a file review, and a hearing by the committee members.

In May 2005, the Office of the Inspector General performed a management review audit of N.A. Chaderjian to provide a baseline assessment of the facility's performance in carrying out its essential functions. The audit found a significant number of serious deficiencies related to counseling services, education, and mental health treatment. The deficiencies were significant enough to indicate that the facility was failing in its core mission of providing treatment and education services to wards. The audit also found that the safety of staff and wards at the facility was jeopardized by the facility's structural and design defects, by poor management practices, and by the failure of the facility to comply with mandated security requirements.

Many of the wards at N.A. Chaderjian are among the most dangerous in the Division of Juvenile Justice's custody and are serving lengthy sentences for crimes such as murder, rape, armed robbery, and assault. Although their crimes were committed while they were juveniles, nearly all wards at N.A. Chaderjian are between 18 and 25 years of age. Most have transferred from other facilities, while others are parole violators. Still others have come from California Department of Corrections and Rehabilitation adult prisons to complete confinement and programming that was suspended when they were convicted of felonies as adults while either in the Division of Juvenile Justice or on parole.

Not only are these wards older and more criminally sophisticated, but many also have histories of being disruptive and dangerous. Many are affiliated with gangs that are active within the facility. Accordingly, they have few privileges to lose by disrupting daily operations. As reported by the Office of the Inspector General in its May 2005 report, ward programming at the facility has diminished in the wake of large-scale fights and assaults on staff resulting in lockdowns of living units. In this environment, the institution had been attempting to implement an "open programming" model in response to the *Farrell v. Hickman* (formerly *Farrell v. Allen*) agreement between the Division of Juvenile Justice (formerly the California Youth Authority) and the Prison Law Office. Under this agreement, the division agreed to correct deficiencies in

medical and mental health care, education, disability services, sex offender treatment, and ward safety and welfare. Among the actions taken by the division have been attempts to restore safe general population programming and to ensure that wards are out of their rooms daily for educational, vocational, and treatment programming, as well as meals and recreation, by June 1, 2005.

Many of the employees at the facility fear for their safety. The facility recorded 12 physical, non-gassing,[1] assaults on staff in 2003, and 23 in 2004. There were also numerous gassing assaults during that period. The level of violence continued in 2005 with 17 non-gassing assaults on staff occurring prior to August 31, 2005, including five assaults in the month of July alone. Again, staff also had to contend with gassings.

The five assaults in July followed the facility's implementation of the open programming model. On July 6, 2005 the acting superintendent placed all of N. A. Chaderjian on lockdown after a serious attack on staff by northern Hispanic gang members residing in the Pajaro Hall general population unit. During the same month the facility took steps to return some living units to normal programming, but the entire facility was again locked down on July 16, 2005 as a result of two additional attacks on staff. During the more than eight-week period following July 6th, northern Hispanic wards in Pajaro Hall were essentially locked down for 24-hours per day except for showers three times per week.

During its special review the Office of the Inspector General identified the following sequence of events based on documentation contained in the Ward's medical records:

Events at the Preston Youth Correctional Facility

April 27, 2004	The Ward arrives at the Preston Youth Correctional Facility. He is given the critical factors assessment for determining need for mental health evaluation. No stated suicidal history or psychiatric problems.
April 27, 2004	Suicide risk screening questionnaire; scores 0 – low risk.
April 28, 2004	Suicide risk screening questionnaire; scores 0 – low risk.
May 3, 2004	The Ward visits nurse to treat eyes for mace exposure after involvement in fight.
May 10, 2004	The Ward visits nurse to treat eyes for mace exposure after involvement in fight.
May 13, 2004	The Ward visits nurse to treat eyes for mace exposure after involvement in fight.
May 16, 2004	The Ward visits nurse to treat eyes for mace exposure after involvement in group disturbance.
May 23, 2004	The Ward visits nurse to treat eyes for mace exposure after involvement in fight.
June 29, 2004	The Ward visits nurse to treat eyes for mace exposure after involvement in group disturbance.
July 17, 2004	The Ward visits nurse to treat eyes for mace exposure after involvement in fight.
July 17, 2004	Suicide risk screening questionnaire; scores 0 - low risk.

[1] "Gassing" is the practice of throwing human excrement or bodily fluids at another person.

August 4, 2004	Psychologist's notes indicate he reviewed the Ward's Youth Authority Administrative Committee file for placement in the special management program. The Ward is almost 18 years old. According to the notes, no significant mental health issues noted or expressed at that time.
October 7, 2004	The Ward completes a sick call form, indicating "I m [sic] been stressing about family problems I need to talk to physic [sic]."
October 7, 2004	The Ward visits doctor for broken hand after involvement in a fight.
October 30, 2004	The Ward completes a sick call form indicating "need to talk to mental health personnel."
November 4, 2004	Psychiatrist's notes on sick call form indicate that "ward was called, the staff reports he is not interested in seeing the psychiatrist."
November 18, 2004	The Ward completes a sick call form, indicating "I need to speak with mental health." Someone, other than the Ward, added "psychologist."
November 19, 2004	Nurse sends referral form to psychologist.
November 27, 2004	The Ward visits medical for exposure to chemical agents after involvement in group disturbance. The Ward refuses medical treatment.
December 6, 2004	The Ward completes a sick call form, indicating "I need to speak to psychologist."
December 7, 2004	The Ward visits medical after re-injuring his right hand following his involvement in a group altercation.
December 13, 2004	The Ward visits medical for minor pain in left hand after his involvement in a fight.
December 16, 2004	Suicide risk screening questionnaire; scored 0 – low risk.
December 16, 2004	The Ward visits medical to treat eyes for exposure to chemical agents after his involvement in a fight.
February 21, 2005	The Ward visits medical for minor cut inside left cheek after his involvement in a fight.
February 22, 2005	The Ward visits medical for a nosebleed after his involvement in a fight.
February 22, 2005	Suicide risk screening questionnaire; scores 0 – low risk.
March 2, 2005	The Ward visits medical after his involvement in a fight. The ward denies having any injuries.
March 2, 2005	Suicide risk screening questionnaire; scores 0; however, detailed review of the document reveals that the total score should have been 2. Both of these scores result in a low risk rating.
March 9, 2005	Psychologist's notes indicate that the Ward was interviewed in a Youth Authority Administrative Committee hearing. The notes state that the Ward is more focused on parole at the earliest date and poorly motivated to address his problems. No symptoms of a major mental disorder, organic brain disease or affective dysfunction were exhibited by the Ward. He remains quite combative and gang-oriented.
March 9, 2005	Suicide risk screening questionnaire; scores 0 – low risk.
March 16, 2005	Psychologist notes that the Ward was interviewed in a Youth Authority Administrative Committee hearing on this date. The notes indicate that the Ward has minimal understanding of the links between his psychological state(s) and his behavioral dysfunctioning. The notes indicated that the Ward is to be transferred to N.A. Chaderjian.

Events at the N.A. Chaderjian Youth Correctional Facility

March 18, 2005	The Ward is transferred to N.A. Chaderjian. Receiving document indicates no history of mental health treatment.
March 18, 2005	Suicide risk screening questionnaire; scores 0 – low risk. (Administered for intake at N.A. Chaderjian.)
March 18, 2005	Suicide risk screening questionnaire; scores 0 – low risk. (Administered for intake at Sacramento Hall.)
April 12, 2005	Suicide risk screening questionnaire; scores 0 – low risk. (Administered for intake at Mojave Hall.)
June 22, 2005	The Ward visits medical for abrasion on the right forearm and left hip area after his involvement in a fight.
June 22, 2005	Suicide risk screening questionnaire; scores 0 – low risk. (Administered for fighting.)
June 23, 2005	The Ward visits medical after his involvement in a fight. Medical staff noted no visible injuries. Notes further indicate the Ward was exposed to mace and showered in the living unit.
June 24, 2005	Suicide risk screening questionnaire; scores 0 – low risk. Comments indicate ward is a danger to others.
July 6, 2005	*Office of the Inspector General note:* *On this date, the acting superintendent placed the entire facility, including Pajaro Hall, on lockdown because of serious assaults on staff by northern Hispanic wards.*
July 29, 2005	Medical notes indicate that the Ward was chemically extracted from his room. He was showered and denied having any injuries. Other institution records indicate that 11 northern Hispanic wards in the Pajaro Hall general population unit covered the windows to their rooms, jammed the doors from the inside, and continued to demonstrate cohesive gang behavior. Verbal instructions were ineffective. Chemical room extractions were required to uncover windows and remove contraband.
August 1, 2005	Medical notes indicate that the Ward had been participating in a hunger strike since July 29, 2005. The notes indicate that the Ward was drinking fluids, his mucous membranes were moist, he was oriented to time, place and person, and he complained about feeling dizzy. The Ward's blood pressure was taken.
August 2, 2005	Medical staff notes indicate that, according to the senior youth correctional counselor, the Ward ate breakfast.
August 31, 2005	Nurse's notes indicate that medical staff were called to Pajaro Hall because the Ward was unresponsive. Ward received cardiopulmonary resuscitation upon medical staff's arrival. The notes also indicate that the Ward did not have a pulse or spontaneous breathing upon the medical staff's arrival.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objective of this special review was to determine whether the Division of Juvenile Justice and the N.A. Chaderjian Youth Correctional Facility had followed key Division of Juvenile Justice policies and procedures for screening, treating, and confining the Ward prior to his suicide, and to determine whether the facility staff followed policies and procedures from the time staff discovered that the Ward had covered his room windows through the time the Department of Corrections and Rehabilitation announced his death. Within the framework of this objective, the Office of the Inspector General set out to answer the following questions:

- Was it appropriate to retain wards on a modified program for such an extended period of time?
- Did the wards receive mandated services during the administrative lockdown?[2]
- Did the Ward receive appropriate mental health assessment and treatment from staff during the administrative lock down?
- Did staff respond to the suicide incident in a timely manner?
- Did the department accurately report the suicide to the media and to other agencies?

In conducting its fieldwork, the Office of the Inspector General performed the following procedures:

- Interviewed the acting superintendent and senior members of the facility staff, including the program administrator of special programs, the chief of security, the Ward's treatment team supervisor, the gang information coordinator, the training officer, two clinical psychologists for the general population units, and one ward.
- Interviewed Division of Juvenile Justice headquarters staff, including the deputy director for institutions and camps, the program administrator for mental health services, the division gang information coordinator, the chief of psychiatry, and the chief of security.
- Reviewed various laws, policies and procedures, and other criteria related to key institution systems, functions, and processes.
- Gathered and reviewed institution logs, witness statements, files, and documents.

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[2] Mandated services are those itemized in section 7270 of the *Division of Juvenile Justice Institutions and Camps Branch Manual.* They include, but are not limited to, services such as exercise, showers, education, legal, counseling and treatment, visiting, dayroom activities, mental health assessment, and medical and dental. Although termed "mandated services," these services can be denied under conditions that jeopardize safety and security.

- Reviewed the department's daily report and subsequent news articles reporting the death of the Ward.

- Analyzed the information obtained from the methods cited above and formulated conclusions.

This special review focused on the Ward, a northern Hispanic ward residing in Pajaro Hall. The documents reviewed by the Office of the Inspector General indicated that northern Hispanic wards also resided in living units other than Pajaro Hall, and that those wards also were locked down and denied mandated services. However, the Office of the Inspector General did not review the duration of the lockdown or the extent to which mandated services were denied to the northern Hispanic wards not residing in Pajaro Hall.

The purpose of this special review was not to establish culpability of any individuals. Instead, the purpose was to determine if there were delays in reporting and responding to the Ward's situation. The Office of the Inspector General did not interview certain key witnesses involved in the suicide response because of the potential for future administrative action against these staff. The Office of the Inspector General did review written statements from these staff members and various other witnesses; however, several of these written witness statements were left intentionally unsigned. In addition, the time of day that specific events occurred, as reported in this special review, are approximations because of inconsistencies in staff accounts and synchronization problems with clocks.

The review team did not review the facility's planning for and implementation of the *Farrell v. Hickman* agreement.

In conducting its work, the Office of the Inspector General found no evidence that the California Department of Corrections and Rehabilitation intentionally or unintentionally misled the media, other agencies, and the public in reporting the death of the Ward. The answers to the remaining four questions are found in the **Findings and Recommendations** section of this report.

FINDINGS AND RECOMMENDATIONS

FINDING 1

Although the lockdown was justified at its inception, the extent to which the Division of Juvenile Justice deprived the Ward and other northern Hispanic wards in Pajaro Hall of services during the lockdown is inconsistent with the Division of Juvenile Justice's mission.

N.A. Chaderjian implemented a facility-wide lockdown following a violent attack on staff by northern Hispanic wards on July 6, 2005. Because lockdowns eliminate or severely curtail mandated services, Division of Juvenile Justice policy requires the facility to periodically complete status reports and obtain approvals from division officials for continuing lockdowns. Although N.A. Chaderjian obtained the required approvals, the eight-week duration of this lockdown and the denial of nearly all services to the northern Hispanic wards in Pajaro Hall created an environment of isolation. During the lockdown, these northern Hispanic wards were isolated in their rooms for nearly 24 hours each day — only leaving about three times per week for showers. This isolation and denial of services is inconsistent with the Division of Juvenile Justice's mission to provide education and treatment to the wards under its care. The effects of this eight-week isolation and service deprivation may have contributed to the Ward's suicide on August 31, 2005.

A serious assault on staff by northern Hispanic wards triggered a facility-wide lockdown. Beginning on July 6, 2005 the acting superintendent of N.A. Chaderjian placed the entire facility on lockdown status after three staff members were attacked by three northern Hispanic gang members residing in the Pajaro Hall general population unit. In this assault, the wards jumped on the staff members, punching and kicking them repeatedly, even after two staff members had been knocked to the floor. As a result, all three staff members suffered head injuries and other trauma. All required hospital treatment. The wards were not injured.

Under lockdown conditions the facility suspends routine programming activity. During this facility-wide lockdown, wards were fed in their rooms rather than in dining areas, wards were denied access to canteen, showers, recreational activities, visiting, religious services, and education services. In addition, wards moving to medical sick call and similar appointments required staff escorts. Security staff also searched all wards' rooms and living units and interviewed the wards. On July 13, 2005, some living units resumed normal programming; but, on July 16 and 17, three additional attacks occurred. In one attack a northern Hispanic ward slipped from his handcuffs and battered a counselor by hitting him in the face. In a separate incident on the same day, another northern Hispanic ward attacked three staff members at mealtime and yet another staff member was injured while restraining the ward. On July 17, a northern Hispanic ward gassed a staff member. These attacks resulted in another facility-wide lockdown. The acting superintendent kept the entire facility locked down until July 20, 2005, when several units resumed regular programming while other halls remained in some form of lockdown condition. For example, the wards in some living units began receiving recreation in small groups and showers under escort.

However, the northern Hispanic gang members in several living units, including Pajaro Hall, remained on a restrictive program called "modified programming" by the Division of Juvenile Justice.[3] In an attempt to secure agreements from the northern Hispanic wards in Pajaro Hall to no longer engage in gang activity, the facility locked wards in their rooms 24 hours a day, except that they received three showers per week and were allowed escorted movement to hearings and sick call. Otherwise, for eight weeks, these wards, including the Ward, received no exercise, education, visiting, dayroom activities, mental health assessment or treatment, or other mandated services.

N.A. Chaderjian serves a ward population of generally older and more serious offenders than those of other Division of Juvenile Justice facilities. Many wards are gang-affiliated and have been sent to N.A. Chaderjian because they have failed at other Division of Juvenile Justice facilities. A few have already served time in adult prisons and have been sent to N.A. Chaderjian to finish out a Division of Juvenile Justice confinement term. According to a staff assault log, there had been 37 assaults against staff, including 20 gassing incidents between January 2005 and August 2005. The gang coordinator told the Office of the Inspector General that the northern Hispanic gang had built a power base "like never seen before" in N.A. Chaderjian. One of the powerful northern Hispanic gang members in Pajaro Hall was described as a "shot caller in the northern gang structure at N.A. Chaderjian," and had previously been identified as the "number two man" at Pleasant Valley State Prison, an adult institution. Shot callers are gang leaders who issue orders to other wards and inmates. They also discipline gang members who fail to follow orders or who try to leave the gang.

In Pajaro Hall, the situation became an apparent deadlock between the northern Hispanic leadership and an administration intent on breaking the gang's will and restoring order. The Ward, possibly along with other northern Hispanic wards, was caught in the middle and faced significant pressure. At five feet, five inches tall and 120 pounds, he was reportedly more of a follower than a leader. Had he attempted to leave the gang, he faced violent retribution by the gang leadership. Yet by standing with the northern Hispanics, he faced the conditions described in this finding. From July 29 until August 2, he went on a hunger strike along with other gang members on lockdown in Pajaro Hall.

Criminally sophisticated former inmates who return to Division of Juvenile Justice custody can significantly disrupt the rehabilitative environment for less sophisticated wards. This condition was evident in the situation in Pajaro Hall at the time of the Ward's suicide. According to an August 11, 2005 memorandum prepared by the division gang information coordinator, wards who return from adult prison with a history of aggressive and assaultive behavior hinder the division's ability to fulfill its mission of treatment and training for wards.

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[3] The division defines lockdown as a facility-wide restriction of services. The term "modified programming" is used to describe restrictions that are applied on a less-than facility-wide basis, such as for a group of wards. Nevertheless, depending on the severity of the modified programming, the denial of services can create the same isolation for wards as that produced by a lockdown.

The lockdown and modified program were initially justified and properly approved. The lockdown and modified program were justified at their inception and were approved according to Division of Juvenile Justice policy. *Division of Juvenile Justice Institutions and Camps Branch Manual* section 7275 describes lockdowns as the restriction of all wards to their rooms following serious threats to facility security and the safety of staff and wards. Given the seriousness of the assaults on staff in July 2005, the lockdown was an appropriate response by the division. Further, the Division of Juvenile Justice followed its policy for approving the lockdown once it extended beyond 72 hours. According to section 7275, any lockdown or modified program lasting longer than 72 hours requires the chief deputy director's approval. Section 7275 further allows mandated services to be suspended but requires that the facility's superintendent assess daily the delivery of mandated services. Mandated services include such essential services as feeding, exercise, mental health, medical care, and daily showers. Among other mandated services are visiting, education, mail, religion, and a grievance process.

The Office of the Inspector General reviewed copies of program status reports related to the lockdown and modified program conditions that were imposed starting on July 6, 2005 and that continued for eight weeks until the Ward committed suicide. The review team found that the documents were approved within 72 hours by the acting superintendent in accordance with *Division of Juvenile Justice Institutions and Camps Branch Manual,* section 7275. Weekly thereafter, the program status reports were approved by the chief deputy director or the deputy director for institutions and camps.

The eight-week duration of the lockdown was inconsistent with the division's mission. Although approved according to policy, the eight-week lockdown and modified program created an environment of isolation inconsistent with the Division of Juvenile Justice's mission to provide education and treatment. Although it followed its own policy in approving the suspension of mandated services via the lockdowns and modified program, the Division of Juvenile Justice created for the northern Hispanic wards on Pajaro Hall an environment of isolation that failed to recognize an increased need for mental health services as mandated services were denied. The northern Hispanic wards had been locked in their rooms for virtually 24 hours a day for eight weeks by August 31, 2005, when the Ward committed suicide.[4] In this environment of isolation, the wards did not receive exercise or education, and according to staff, had no contact with mental health treatment staff. This resulted in a condition contrary to the Division of Juvenile Justice's stated mission, which is as follows:

> *To protect the public from criminal activity by providing education, treatment, and training services for youthful offenders committed by courts; assisting local juvenile justice agencies with their efforts to control crime and delinquency; and encouraging the development of state and local programs to prevent crime and delinquency.*

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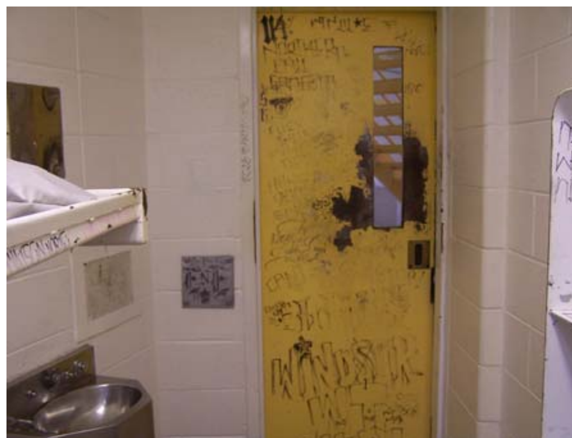
[4] The northern Hispanics continued on the modified program after the Ward's suicide. According to the acting superintendent of N.A. Chaderjian, the northern Hispanic wards living in Pajaro Hall returned to regular programming on October 12, 2005—approximately six weeks later. Therefore, they had been on modified program for a total of 14 weeks.

According to the weekly progress report reviewed by the special review team, the northern Hispanic wards in Pajaro Hall received only limited access to showers—mostly restricted to Mondays, Wednesdays, and Fridays. Further, during the eight-week period, the northern Hispanic wards were never allowed to leave their rooms for large muscle exercise, had very limited access to counseling services, and did not receive other mandated services such as education, visiting, and telephone access. This deprivation of critical services, such as exercise, mental health counseling and assessment, and education, sharply contrasts with the Division of Juvenile Justice's mission to educate, treat, and train youthful offenders.

Picture taken from doorway, looking into the Ward's room



Picture taken inside the Ward's room, looking toward doorway.

The Ward did not have effective access to mental health programming and other services that might have addressed the predicament in which he found himself after eight weeks of service deprivation. According to a facility staff member who interviewed the Ward during the lockdown, the Ward was "in a bad spot; he could not denounce his gang." The division's program administrator for mental health services told the Office of the Inspector General that after learning that the Ward had been under a lockdown for a long period and had engaged in a hunger strike, she would have referred him for an evaluation to determine whether he would have benefited from a special counseling program.

The Office of the Inspector General reported similar problems in January 2005. The long-term isolation of wards in their rooms for 23 hours or longer each day continues to be a problem for the Division of Juvenile Justice. In December 2000, the Office of the Inspector General reported that 16 percent of wards sampled at six facilities were on 23-and-1 schedules, a practice of confining wards to their rooms for 23 hours per day. In January 2005, the Office of the Inspector General issued its Accountability Audit, a review of previous audits of the California Youth

Authority (now the Division of Juvenile Justice). Among its more important findings, the Office of the Inspector General reported the ongoing existence of 23-and-1 confinement practices. The Office of the Inspector General found these practices even after the then-director of the California Youth Authority announced in his August 2004 confirmation hearing before the Senate Rules Committee that 23-and-1 confinement practices had ended. The report stated:

> *Despite recent efforts by the new department director to remedy the situation, large numbers of wards in California Youth Authority facilities throughout the state—9 percent of the wards at the five facilities audited—are still confined to cells 23 hours a day with little opportunity for education and training and minimal access to counseling and other treatment services.*

The Office of the Inspector General expressed concerns about the effects of such a schedule on the wards:

> *Long periods of isolation and the consequent lack of sensory stimuli may also increase the wards' needs for mental health services, which are in short supply. Simply put, the long-term isolation of young people entrusted to the State is both ineffective and dehumanizing. The practice of 23-and-1 confinement should cease as soon as possible.*

In summary, staff and ward security concerns initially justified the use of lockdown and modified programming at N.A. Chaderjian in July 2005. Although the facility obtained required approvals for continuing the lockdown and the modified programming, the eight-week duration of the lockdown and the nearly complete denial of mandated services created an environment of isolation and sensory deprivation for the northern Hispanic wards in Pajaro Hall. The conditions contrast sharply with the Division of Juvenile Justice's mission of education, treatment, and training. Further, under these conditions, the Ward was faced with two difficult options: renouncing his gang (and suffering violent retribution at the hands of a gang shot-caller) in exchange for his return to normal programming, or staying with the gang and continuing to live in conditions he was finding increasingly intolerable. On August 31, 2005 the Ward chose suicide.

RECOMMENDATIONS

The Office of the Inspector General recommends that the Department of Corrections and Rehabilitation take the following actions to minimize the use of lockdowns or modified programs that deprive wards of mandated services:

- **Immediately end the practice of isolating wards in their rooms over extended periods of time.**

- **Require written approval by the secretary of the Department of Corrections and Rehabilitation for the placement of wards on lockdown or modified programs beyond 14 days. In addition, similar to existing policies and procedures for special management program extensions, the department should require the Division of Juvenile Justice to develop policies and procedures specifying that the restricted**

program review committee shall approve or deny the continuation of wards' placement on lockdown or modified program beyond 30 days, and then every 15 days thereafter, subject to the approval of the secretary.

- **Require the Division of Juvenile Justice to develop policies and procedures that provide a minimum level of mental health intervention by mental health professionals during lockdowns or modified programs that exceed 14 days.**

- **To ensure that wards receive assessment and counseling as needed, the department should monitor the Division of Juvenile Justice's provision of mental health services during lockdowns and modified programming that exceed 14 days as required in the policies and procedures recommended above.**

- **Work with the Legislature and the courts to end the practice of returning adult inmates to Division of Juvenile Justice facilities.**

FINDING 2

The Division of Juvenile Justice failed to assess or act on the Ward's mental health needs.

The Division of Juvenile Justice failed several times to properly assess the Ward's mental health to determine if he was properly placed into the general population of N.A. Chaderjian. The division also missed several signals that should have caused it to provide him with mental health services. For example, the Ward requested four times to be seen by mental health staff, but he was never seen. In addition, it appears that the division failed to recognize possible mental health issues when the Ward first arrived at the Preston Youth Correctional Facility and it neglected to make an appropriate referral to obtain an in-depth mental health assessment. Finally, the Division of Juvenile Justice does not yet use a custody classification system that would help it distinguish between criminally unsophisticated wards and those who are very hardened and criminally sophisticated. As a result of these failures, the Ward may have been improperly placed in a general population living unit, rather than in a specialized treatment unit; and, just as importantly, may have been improperly placed in N.A. Chaderjian.

The Division of Juvenile Justice has mental health programs available for wards. Within 21 days of admission to the Division of Juvenile Justice, wards are to be given a treatment needs assessment, which is a battery of tests designed to assess a ward's mental health characteristics. According to *Division of Juvenile Justice Institutions and Camps Branch Manual* section 6260, specific mental health problems identified during the assessments—suicide, anger, or thought disorder—must be given "red flags" and forwarded promptly to the senior psychologist or a treatment needs assessment psychologist. The senior psychologist or treatment needs assessment psychologist then reviews the treatment needs assessment report and refers a ward for an in-depth psychological evaluation, psychiatric assessment, or other services as indicated.

If the treatment needs assessment does not identify issues needing further assessment, a ward will likely be placed in the general population. Alternatively, if the results of the treatment needs assessment identify a need for subsequent psychological evaluations or psychiatric assessments, a ward may receive a "special program assessment of needs" evaluation. The special program assessment of needs evaluation determines whether a ward needs to be placed in a specialized program, or should be placed in the facility's general population.

In addition to general population housing, N.A. Chaderjian has several specialized programs for wards, including drug and alcohol treatment, intensive psychiatric treatment, parole violator programs, special counseling programs for wards who exhibit symptoms of mild to moderate mental illness, sex offender programs, and a special management program for violent and disruptive wards. One of the primary differences between general population housing and a specialized program is the amount and quality of counseling and mental health treatment services provided to wards. In the specialized programs, the counselors have smaller caseloads than counselors in the general population. Moreover, the specialized programs have mental health professionals, such as psychologists or psychiatrists, assigned to the living unit whereas a general

population unit does not have an assigned staff psychologist or psychiatrist. Instead, general population units have access only to a psychologist shared by three or four living units.

The Division of Juvenile Justice also has a suicide prevention, assessment, and response program. The program requirements make all staff responsible for taking immediate action when wards exhibit suicidal thoughts, feelings, or behavior. The policy, outlined in *Division of Juvenile Justice Institutions and Camps Branch Manual* sections 6263 through 6272 further defines certain high-risk periods and behaviors that may be indicative of potential suicide. A multi-disciplinary approach is prescribed within the policy, which includes identification, assessment and referral, prevention, intervention, communication, monitoring, housing, review, and training elements. Suicide prevention, assessment, and response are critically important concepts in Division of Juvenile Justice facilities, where suicide risk is generally high. Since January 2004, there have been three suicides, including the Ward's, in Division of Juvenile Justice facilities.

As part of its suicide prevention, assessment, and response program, the Division of Juvenile Justice uses a suicide risk screening questionnaire as a tool to assess wards' suicide risk. The suicide risk screening questionnaire is designed to be administered by both health care and non-health care staff at various times during a ward's commitment, such as upon admission, or when high-risk factors are present. All facility staff members, contractors, and volunteers who have ward contact are required to attend annual refresher training on the division's suicide prevention, assessment, and response program.

A previous review by the Office of the Inspector General found deficiencies in the suicide prevention, assessment, and response program at N.A. Chaderjian. The Office of the Inspector General reported in its May 2005 management review audit that the suicide prevention, assessment, and response program was severely deficient. The report listed several deficiencies, including a lack of leadership within the suicide prevention program, poor attendance at suicide prevention committee meetings, and staff members not receiving annual refresher training.

Despite the Office of the Inspector General's report, some of the staff directly involved in the Ward's care on August 31, 2005 still had not received the annual refresher training in suicide prevention required by Division of Juvenile Justice policy. The Office of the Inspector General reviewed training records from January 2003 through November 2005 and found that two staff members responsible for the Ward's custody and care on the day of his suicide had not received required annual refresher training in suicide prevention. One of the custody staff on duty on August 31, 2005 had last received the refresher training in November 2003. The casework specialist, who periodically performed mental health "check-ins" with the Ward, had not received the suicide prevention training since November 2003.

The Ward did not receive key mental health services. Despite the availability of these specialized programs and services, the Division of Juvenile Justice failed to provide the Ward with certain key mental health services. During the special review, the Office of the Inspector General identified four occasions in which the Division of Juvenile Justice either did not follow

its own policies or did not take reasonable steps to provide mental health services to the Ward. As explained in more detail below, at issue are the following:

- The Ward's treatment needs assessment appears to have identified a mental health issue that staff should have, but did not, refer for further assessment. The Office of the Inspector General, however, could only infer this from available health records because the Division of Juvenile Justice could not find the treatment needs assessment.
- The Ward made repeated requests to be seen by mental health personnel, only one of which was acted upon.
- The Ward did not receive a mental health or suicide risk assessment during his isolation.
- The Ward participated in a three-day hunger strike about 30 days prior to his suicide.

The Ward's treatment needs assessment appears to have identified a mental health issue that staff should have, but did not, refer for further assessment. The Division of Juvenile Justice could not locate a copy of the treatment needs assessment that should have been performed on the Ward when he first entered the Preston Youth Correctional Facility in April 2004. The casework supervisor at the Preston Youth Correctional Facility told the Office of the Inspector General that the treatment needs assessment should be located in the Ward's unified health record, which includes all records of medical, mental health, and dental treatment rendered to a ward. The Office of the Inspector General's team reviewed the file and did not find a treatment needs assessment in the Ward's unified health record or other possible locations. The review team did find a reference to the treatment needs assessment in other documents kept in the Ward's unified health record and, therefore, concluded that the treatment needs assessment was completed.

These documents noted that "his treatment needs assessment scoring report reflected high levels of concern under drug/alcohol use, impulsivity, and anger." According to the *Division of Juvenile Justice Institutions and Camps Branch Manual,* section 6260, the high level of anger should have raised a "red flag" and a referral to the senior psychologist or the treatment needs assessment psychologist. Further, section 6260 requires the casework specialist to note any area appearing to require additional exploration or attention. According to a retired senior psychologist contacted by the Office of the Inspector General, the impulsivity coupled with anger shows potential for even greater risk and should have prompted additional exploration and attention. The Office of the Inspector General's review of the unified health record revealed that such a referral was not made and no subsequent in-depth psychological evaluation or psychiatric assessment was conducted.

The Ward made repeated requests to be seen by mental health personnel, only one of which was acted upon. The Ward tried four times to be seen by mental health personnel, but contrary to a Division of Juvenile Justice policy requiring access to health care, only one request was acted upon. On October 7, 2004, at the Preston Youth Correctional Facility, the Ward submitted a ward request for sick call, stating "Im [sic] been [sic] stressing about family problems I need to

talk to physic [sic].” Again on October 30, 2004, the Ward submitted a ward request for sick call, stating “need to talk to mental health personnel.” On November 4, 2004, the Ward was offered an opportunity to see a psychiatrist, but the records indicate he refused, stating “ward called and staff reports he is not interested in seeing the psychiatrist.” Even after refusing the offer to be seen by mental health staff the Ward made two more written requests, on November 18 and December 6, to talk to mental health staff. There is no indication in the records that he was provided with an opportunity to talk to mental health staff in response to these two requests. *Division of Juvenile Justice Institutions and Camps Branch Manual* section 6167.5 (temporary departmental order) states that wards shall have access to emergency health care 24 hours a day, seven days a week, and have access to necessary health care five days a week. However, the division does not have specific procedures for responding to ward requests for mental health services.

Regarding the Ward’s refusal to be seen by the psychiatrist, the Division of Juvenile Justice’s chief of psychiatry told the Office of the Inspector General that it is not sufficient to ignore the Ward’s refusal. He stated that the Ward “should have been asked several times to at least assure his symptoms are explored.”

The N.A. Chaderjian gang information coordinator told the Office of the Inspector General that northern Hispanic gang members oppose mental health treatment and that they place significant pressure on individual members within their group. This pressure may explain why the Ward had twice previously requested mental health services but then rejected an offer to see a psychiatrist. He subsequently made two additional follow-up requests. The Ward may have felt compelled to reject the offer in front of his fellow gang members.

The Ward did not receive a mental health or suicide risk assessment during his isolation. The Ward was isolated in his room for eight weeks without receiving a suicide risk assessment questionnaire or a thorough assessment of his mental health state. He did not receive a suicide risk screening questionnaire during the eight-week administrative lockdown. The *Division of Juvenile Justice Institutions and Camps Branch Manual* section 6263 states that wards may become suicidal at any point and that certain high-risk periods, including a lockdown, can elevate the risk. During the entire eight weeks, the northern Hispanics living in Pajaro Hall, including the Ward, were isolated in their rooms for nearly 24 hours per day and received only a few of the required mandated services—essentially only feeding, occasional showers, and very limited contact with a caseworker. As discussed in **Finding 1**, this eight-week deprivation of services was not only inconsistent with the Division of Juvenile Justice’s mission to provide education and treatment to wards, but it might also have had a serious effect on the Ward’s mental health.

During the eight weeks the Ward was isolated in his room, he received no contact from qualified mental health professionals, and only brief contact by various caseworkers who provided “check-in” counseling through the ward’s door. After reviewing the caseworks’ notes, the Office of the Inspector General found that the Ward had 16 visits by caseworkers during the eight-week lockdown—about two visits per week. The caseworkers’ notes mention comments made by the

Ward, including that he was "feeling claustrophobic," and "he's feeling agitated." Despite these signs and symptoms, the caseworkers did not refer the Ward for clinical assessment.

A Division of Juvenile Justice psychologist who wrote the confidential operational analysis report on the Ward's suicide told the Office of the Inspector General that these caseworkers are not mental health staff and are not supervised by mental health practitioners. By contrast, as specified in *Division of Juvenile Justice Institutions and Camps Branch Manual* section 7285, violent and disruptive wards who are placed in the Division of Juvenile Justice's structured special management program receive integrated program services that include psychological and psychiatric services.

The Ward participated in a three-day hunger strike about 30 days before his suicide. The Ward engaged in a three-day hunger strike starting on July 29, 2005, along with nine others in Pajaro Hall. The facility's gang information coordinator told the Office of the Inspector General that the Ward's hunger strike was part of the gang pressure the Ward lived under. With respect to the Ward's gang activity, the gang information coordinator said that the Ward was weak and the facility was unable to protect him. The gang information coordinator added that the Ward was "down for his cause," but he was in over his head and was "locked into his pattern." The psychologist who authored the division's confidential operational analysis report on the Ward's suicide told the Office of the Inspector General's review team that the Ward's participation in a hunger strike should have been addressed by clinical mental health staff, but it never was. Further, the division's program administrator for mental health services told the Office of the Inspector General that in response to the Ward's hunger strike, she would have referred him for a special program assessment of needs and recommended that a psychologist evaluate him.

The Ward may have been improperly placed. As a result of the Division of Juvenile Justice's failure to provide the Ward with key mental health services, he may have been improperly placed in the general population living unit, rather than in a specialized treatment unit. Moreover, had the Division of Juvenile Justice followed its own policies or reacted to some of the signals described above, the Ward's apparent mental health problems might have been detected.

The possibility that the Ward might have been better off placed in a different facility was raised by the Division of Juvenile Justice's gang information coordinator. He told the Office of the Inspector General that given the Ward's brief stay with the division, his commitment offense, and small physical stature (five feet, five inches, 120 pounds), combined with his dependent type of personality, his placement at N.A. Chaderjian was questionable. The gang information coordinator further expressed the belief that the Preston Youth Correctional Facility, where the Ward was first committed, should have worked with the Ward longer. He further commented that the Ward was "overmatched" at N.A. Chaderjian.

The Division of Juvenile Justice does not have a custody classification system. The Ward may have been placed in a different facility if the Division of Juvenile Justice used a custody classification system. Such a system identifies security and other factors that would help the Division of Juvenile Justice distinguish between violent, criminally sophisticated wards and less violent, unsophisticated wards. This lack of a custody classification system was reported to the

Division of Juvenile Justice in a December 2003 report titled *General Corrections Review of the California Youth Authority.* This report noted the following:

> *[D]etailed information on wards is not systematically utilized for assignments to living units or facilities. YA has become more focused on program assignments of wards to formalized drug treatment units, Intensive Treatment Programs, and Specialized Counseling Programs. It is still unclear how many wards that ought to be placed in these special programs are currently housed in other units.*

The Division of Juvenile Justice recently acknowledged its lack of a custody classification system in its November 30, 2005 report titled *Safety & Welfare Remedial Plan*. In this report, the division notes that in 2004 it developed an interim security classification assessment that classified wards into four levels: low-, moderate-, medium-, or high-risk for institutional violence. The implementation of this security classification assessment, however, was postponed because of a lack of single-room living units in northern California, funding constraints, and concerns about the validity of the assessment tool. The *Safety & Welfare Remedial Plan* further states that the Division of Juvenile Justice will contract for the "identification/development of a comprehensive risk/needs assessment."

All wards received a suicide risk screening the day after the Ward's suicide. The Division of Juvenile Justice informed the Office of the Inspector General of action it took following the Ward's suicide. According to a September 2, 2005 memorandum obtained by the Office of the Inspector General's special review team, all wards at N.A. Chaderjian were given a suicide risk screening questionnaire on September 1, 2005, the day after the Ward's suicide. This memorandum, prepared by a senior psychologist, added that the completed suicide risk screening questionnaires were reviewed by the senior psychologist and that 137 wards were designated for follow-up.

RECOMMENDATIONS

The Office of the Inspector General recommends that the management of the N.A. Chaderjian Youth Correctional Facility take the following actions:

- **As recommended in the Office of the Inspector General's May 2005 management review audit, ensure that all staff members, contractors, and volunteers who have contact with wards receive the annual suicide prevention training required by section 6263 of the *Division of Juvenile Justice Institutions and Camps Branch Manual.***

- **Ensure that staff members administer suicide risk assessment questionnaires as required by existing policy.**

The Office of the Inspector General also recommends that the management of the Preston Youth Correctional Facility take the following action:

- **Ensure that it complies with existing treatment needs assessment policies and procedures, including those that require specific mental health problems identified during the assessments—suicide, anger, or thought disorder—be given "red flags" and forwarded promptly to the senior psychologist or treatment needs assessment psychologist.**

The Office of the Inspector General also recommends that the administration of the Division of Juvenile Justice take the following actions:

- **Develop procedures, similar to medical sick call procedures, that require mental health staff to respond to ward interview requests in a timely and appropriate manner and ensure that treatment occurs. To ensure compliance, the facilities should track the ward requests and document the interviews.**

- **Develop and implement a custody classification system. Included in this system should be an instrument designed to assist in identifying the most appropriate placement for wards. The instrument should consider whether a ward has the sophistication and maturity level for the recommended placement.**

FINDING 3

Living unit staff and communication center staff failed to follow key policies and procedures, resulting in a period of 38 minutes before staff opened the Ward's door. However, it is not possible to determine whether a faster response would have saved his life.

At approximately 6:15 p.m. on August 31, 2005, the staff in Pajaro Hall discovered that the Ward had covered his windows, could not be seen in his room, and was not responding to attempts to communicate with him. Despite a policy requiring the immediate reporting of such conditions, Pajaro Hall staff did not report the situation to the control sergeant for approximately 15 minutes. The control sergeant, after learning of the Ward's status in Pajaro Hall, delayed in communicating with the watch commander and in dispatching the search and escort team. Consequently, it took an additional 23 minutes for these staff members to arrive and open the Ward's door. As a result, 38 minutes passed between the time the living unit staff identified the Ward's situation and his room door was opened at 6:53 p.m. This 38-minute period resulted in a response so prolonged it could not be expected to successfully prevent the suicide of the Ward. However, given the lack of information on the precise time of the suicide and the fact that death by hanging can occur within six minutes, it is not possible to determine whether a more timely response would have saved the Ward's life.

Ward suicide is a constant risk in a youth correctional facility. The Division of Juvenile Justice recognizes this risk and the fact that many suicide attempts are by hanging. In response, the division has developed the suicide prevention and response program discussed in **Finding 2** of this report. In addition, the division has developed various other policies and procedures for responding immediately to possible suicide attempts. For example, Hoffman tools (cut-down knives) are required to be available in each Division of Juvenile Justice living unit to permit staff to quickly cut through any material a ward may use to hang himself. The Office of the Inspector General verified that staff used a Hoffman tool to cut down the Ward.

Wards' rooms at N.A. Chaderjian have small interior windows through which staff can observe wards' activities. These rooms also have exterior windows. It is critical that staff's view into the rooms be unobstructed so that staff can verify that wards are not injured, have not escaped, or are not behaving in a manner that could potentially injure themselves or staff. However, wards occasionally cover their windows to obtain privacy or to hide illicit behavior. Covering windows can also be a precursor to a ward's suicide attempt. Accordingly, the facility prohibits wards from covering their windows and policy requires that staff visually check wards' rooms every 30 minutes. The Office of the Inspector General's review of log entries for Pajaro Hall verified that staff were conducting room checks at least every 30 minutes.

However, as discussed below, the Office of the Inspector General found that facility staff failed to follow other key policies and procedures, resulting in an unreasonable response time.

The staff response time of approximately 38 minutes was unreasonably long. Despite the well-established risks of self-injurious behavior associated with a ward covering his room's windows, living unit and custody staff failed to follow key policies and procedures and may also have been confused by multiple and conflicting policies and procedures, resulting in an elapsed time of approximately 38 minutes to respond to the Ward's suicide attempt. Specifically, the Office of the Inspector General found the following:

- ***Pajaro Hall staff ignored the Ward's covered room windows for ward count purposes.*** *Division of Juvenile Justice Institutions and Camps Branch Manual,* section 1815 states that "room check procedures for all wards housed in individual rooms shall require staff to conduct visual checks of all rooms, and wards who are present within those rooms, at varying intervals not to exceed thirty minutes." This section further states that "When counting wards, staff shall observe skin and check for breathing or movement, and other signs of life, and document the count in the unit log." Section 1815 further provides that "If it is suspected that a ward is missing or when there is a discrepancy in the count, immediately contact the control sergeant." These room checks are designed to assure that wards are safe and to "lead to a faster response to a ward with medical emergency."

  Despite having a policy requiring staff to visually observe the ward and verify signs of life, it appears that staff failed to do this and then failed to report to the communication center that the Ward was unresponsive. During the time the Ward was in room 4 with his windows covered, staff conducted two room checks – one at 6:15 p.m. and another at 6:44 p.m.

Entrance door into the Ward's room

Exterior view of the rear window of the Ward's room

- ***Staff failed to report that the Ward was unresponsive after covering his windows.*** Pajaro Hall living unit staff delayed reporting to the communication center control sergeant that the Ward was unresponsive after covering his windows. According to witness statements, Pajaro Hall staff first noticed at approximately 6:15 p.m., during the room checks, that the Ward had covered his windows and was unresponsive. A youth correctional counselor tapped the room window with keys, knocked loudly, and asked the Ward if he was alright. The Ward did not respond. Witnesses said that three youth correctional counselors and a youth correctional

cadet were on duty in Pajaro Hall at the time. Still another youth correctional counselor was working in the unit control tower overseeing dayroom activities and controlling entry and exit to Pajaro and Owens Halls. Despite the Ward's unresponsiveness, the youth correctional cadet and the youth correctional counselor who first noticed the Ward's situation both left Pajaro Hall to assist with ward programming in Owens Hall.

Between 6:15 p.m. and 6:30 p.m., another Pajaro Hall youth correctional counselor walked to Owens Hall and discussed the Ward with the youth correctional counselor who first discovered the Ward 's condition. They returned together to Pajaro Hall and made another unsuccessful attempt to obtain a response from the Ward. Based on notations in the Pajaro Hall log book, staff waited until 6:30 p.m., a period of 15 minutes, before informing the communication center that the Ward had covered his windows and was unresponsive. As required by the *Division of Juvenile Justice Institutions and Camps Branch Manual,* section 1815, upon finding that the Ward's window was covered and the Ward was unresponsive the staff should have immediately contacted the control sergeant in the communication center.

- ***Multiple and conflicting policies and procedures contributed to the delay.*** During the period after the living unit staff found that the Ward had covered his windows and was unresponsive and before the search and escort team arrived, Pajaro Hall staff did not open the room door to check the Ward's status. Presumably staff did not open the room because of a policy memorandum dated August 18, 2005, authored by the acting superintendent of N.A. Chaderjian. This policy requires four staff to be present at the door of any ward in lockdown status for the purpose of feeding or showering. This policy is a response, in the interest of staff safety, to the many assaults on staff that have occurred in recent months at N.A. Chaderjian. The policy memorandum implicitly acknowledges the risks associated with the unlock procedures. It concludes that "any issues or concerns must be immediately reported to the Watch Commander and/or Unit Supervisor or Manager."

  Through interviews, the Office of the Inspector General became aware of a practice employed at N.A. Chaderjian that was not addressed in written procedures or in the superintendent's August 18, 2005 memorandum. Under this practice, the watch commander or the search and escort unit would respond to calls involving any ward who had covered his window to block staff's view into his room. Living unit staff would report such incidents to the control sergeant and await assistance from the watch commander and the search and escort staff. After arriving, the officers would secure a chain across the room door to limit the door's opening and thus prevent the possibility of a ward pushing the door open suddenly to assault staff. This procedure would allow the door to be opened just enough to allow staff to check on the safety of the ward and remove the window obstruction without having to remove the ward. The watch commander's presence was necessary for this procedure because the only chain used was kept in the watch commander's vehicle. According to staff, the practice of using the chain to open a ward's door was implemented sometime prior to the facility-wide lockdown that occurred on July 6, 2005 and was common practice. The practice provided for the safety of both wards and staff.

Notwithstanding the acting superintendent's policies in his memorandum of August 18, 2005, and the practice of using a chain to gain access to the interior of a ward's room, the *Division of Juvenile Justice Institutions and Camps Branch Manual* provides options for the immediate use of force under certain circumstances. Section 2083 of the manual states that "staff may use immediate force when the behavior of the ward(s) constitutes an imminent threat to the safety of any person or persons or the security of the institution." An unresponsive ward concealed from the view of staff could constitute an imminent threat to the safety of that ward. The chief of security operations for the Division of Juvenile Justice told the Office of the Inspector General that, because the Ward could not be seen by staff and was unresponsive, the situation should have been handled as an immediate use of force by staff. However, because of the conflicting policies and procedures described above, the Office of the Inspector cannot conclude whether the living unit staff should have entered the Ward's room. Such a conclusion can only be drawn from a thorough administrative investigation.

As of December 15, 2005, the facility had formalized and implemented its local operating policy regarding the use of safety chains on doors to rooms in which wards have covered their windows. The new policy states that if a ward does not respond verbally to staff instructions, staff will immediately notify the communication center, apply the chain, utilize a face shield, and open the door sufficiently to remove the obstruction from the window. This new policy allows for an immediate response by staff while providing for their safety.

- ***The control sergeant did not promptly forward critical information.*** The control sergeant failed to forward critical information promptly to the watch commander and the search and escort staff. The control sergeant works in the central control tower with a view of all of the six living unit buildings on facility grounds. In addition to coordinating each living unit's security activities by monitoring ward counts, security fences, alarm systems, and ward movements, the control sergeant serves as a dispatcher by coordinating communications among personnel in operations, facility management, and security.

  The watch commander is responsible for assessing pending security issues on facility grounds. He does so by evaluating information received from the control sergeant along with information already available to him through personal observation and reports from search and escort teams under his command. After assessing available information, the watch commander makes decisions as to the priority of each pending issue and directs the control sergeant in the tower to dispatch search and escort teams accordingly. Because of his overall responsibility for security issues, the watch commander cannot effectively direct search and escort staff to respond to events requiring attention if the information provided by the control sergeant is not clear, complete, and timely.

  When the control sergeant first learned of the Ward's situation in Pajaro Hall, the watch commander and the search and escort units were already responding to an incident in Kern Hall. The control sergeant stated he accessed the facility's database and noted that the Ward was classified as a "low suicide risk." As a result, the sergeant decided that the search and

escort units could finish their call at Kern Hall before responding to the Ward. However, this was not his decision to make; it was the watch commander's.

The control sergeant misread the urgency of the situation in Pajaro Hall. Witnesses confirmed that the control sergeant did not inform the watch commander and the search and escort units of the Ward's situation until after they had departed Kern Hall. This failure to act is contrary to the control sergeant's duty description, which places him under the direct supervision of the watch commander and requires him to "Communicate precisely and timely any and all emergencies that may hinder the normal function or operation of the institution." The sergeant's failure to act is also contrary to *Division of Juvenile Justice Institutions and Camps Branch Manual,* section 2092, which requires the control sergeant to notify the watch commander of any request for a room extraction. The section defines a room extraction to include an emergency in which there is threat of death or great bodily injury to staff or wards. It further instructs the control sergeant to dispatch resources as directed by the watch commander and adjust institutional operations as necessary. Given that the Ward had covered his windows and was not responding to staff, the control sergeant should have communicated the situation to the watch commander immediately as directed by the acting superintendent's August 18, 2005 memorandum on unlock procedures. The control sergeant's failure to inform the watch commander of the Ward's condition and to obtain operational instructions resulted in an additional delay. However, as explained later in this finding, the Office of the Inspector General is unable to determine the amount of time attributable to this delay.

The Kern Hall incidents were lower priority events. At 6:17 p.m., Kern Hall living unit staff reported to the control sergeant that a ward was threatening to gas (throw bodily waste or fluids on) staff in the living unit. Kern Hall is N.A. Chaderjian's special management program, housing wards with serious behavioral issues. Upon arriving at Kern Hall, the watch commander and the search and escort unit learned that the gassing threat was not directed at staff, but rather involved two wards in adjacent recreation areas. The problem had already been brought under control by Kern Hall staff by the time the watch commander arrived; however, based on witness statements, it appears that no one informed the control sergeant that the situation was under control.

While the watch commander was still at Kern Hall, another ward refused to leave his recreation yard in protest of his room assignment. The watch commander engaged in a lengthy discussion with this ward to address his complaint. While the watch commander and the search and escort units dealt with this second Kern Hall situation, they remained unaware that the Ward had covered his windows and was unresponsive, a problem more serious than either of those at Kern Hall.

The Office of the Inspector General learned that none of the wards involved in the Kern Hall incidents to which search and escort units responded received behavior reports for their actions, suggesting that these incidents were relatively routine. Nonetheless, search and escort staff remained involved with these less-serious incidents because the control sergeant did not inform the watch commander about a more serious situation affecting another ward's health and well being.

At the time the control sergeant observed the search and escort unit depart Kern Hall, the control sergeant instructed the search and escort unit to respond to the Ward's situation in Pajaro Hall without first talking to the watch commander. The control sergeant directed the search and escort unit to check the back windows of rooms 4 and 18 because both rooms' windows had been covered by the occupants. The ward in room 18 communicated with staff, and the search and escort unit noted that the ward peered through his door window. However, the search and escort unit could not see into the back window of the Ward's room. While the control sergeant directed the search and escort unit, the watch commander departed from Kern Hall still unaware of the incident unfolding in Pajaro Hall. When the watch commander arrived at the communication center he was informed of the situation in Pajaro Hall, and he responded immediately.

Conflicting times reported for the same event. The living unit and the communication center reported different elapsed times for the same event. The living unit staff reported that 23 minutes elapsed between the time they requested assistance from the watch commander via the communication center and the time the Ward's door was opened. In contrast, the control sergeant in the communication center reported that 12 minutes elapsed between the time he received the call for assistance from the living unit staff and the time the living unit staff reported the need for medical assistance, which occurred immediately after the Ward's door was opened. After reviewing documents and witness statements, the Office of the Inspector General concluded that the 23 minute time frame recorded by the living unit staff is more reliable than the 12 minute time frame reported by the control sergeant in the communication center. The living unit elapsed time is based on log book entries which appear to have been created contemporaneously. Furthermore, there are many staff statements that coincide with the log book. On the other hand, the control sergeant in the communication center expressed concern about the reliability of the communication center clock. Moreover, the entries in the communication center log book were incomplete.

The living unit staff reported that the request for assistance was made at 6:30 p.m., whereas the communication center staff reported that the request was received at 6:36 p.m. This six minute difference could easily be explained by a lack of synchronization between the clocks. However, even though the clocks are not synchronized, the lack of synchronization should not cause the 11 minute difference in the elapsed times reported by the staff in each location.

To gain additional information regarding staff's response time to the incident, The Office of the Inspector General reviewed a digital copy of the video recording in Pajaro Hall on the evening of the suicide. Because the recording did not include a time and date stamp feature, it could not be used to precisely analyze the time of events.

There is no assurance that facility staff could have saved the Ward. No one knows when the Ward's hanging began because he was alone in his room with the windows covered. The hanging occurred between the last time the Ward was observed in his room, moments before 6:15 p.m., and the time staff opened his door at 6:53 p.m. The 38 minutes it took to respond to his situation was unreasonable, and it resulted in a response so prolonged it could not be expected to successfully prevent the suicide. However, given that death by hanging can occur within six minutes and that staff were following policy by checking wards' rooms every 30 minutes, there

was ample time for the Ward to complete the suicide between room checks. Therefore, there is no assurance that the facility staff could have saved the Ward's life.

RECOMMENDATIONS

The Office of the Inspector General recommends that the N.A. Chaderjian Youth Correctional Facility take the following actions:

- **Ensure that all incidents requiring a search and escort response be communicated to the control sergeant and the watch commander in a timely manner as required by the *Division of Juvenile Justice Institutions and Camps Branch Manual*.**

- **Ensure that the watch commander communicates back to the control sergeant when a threat or other security situation is resolved.**

- **Develop and implement policies and procedures for ensuring that all facility clocks are synchronized.**

- **Modify the existing video system so that it will accurately date and time stamp all video recordings. Also, place a synchronized living unit clock in plain sight of the camera view to facilitate living unit log entries.**

The Office of the Inspector General acknowledges that it is difficult, if not impossible, to develop policies and procedures for every situation facility staff face. However, given the recurring problem of wards covering their windows, the Office of the Inspector General recommends that the Division of Juvenile Justice review the policies and procedures in the *Division of Juvenile Justice Institutions and Camps Branch Manual* and consider adding detailed policies and procedures for addressing all aspects of wards' covering their room windows, including communication, removing visual obstructions, entering rooms, and disciplining wards.

Finally, the Office of the Inspector General recommends that the Department of Corrections and Rehabilitation Office of Internal Affairs consider the information presented in this report in conducting its investigation into the culpability of specific individuals associated with the delay in responding to the death of the Ward.

Response from the Department of Corrections and Rehabilitation

OFFICE OF THE SECRETARY

1515 S STREET, 95814
P.O. BOX 942883
SACRAMENTO, CA 94283-0001

December 27, 2005

Mr. Matthew L. Cate
Office of the Inspector General
Inspector General
P.O. Box 348780
Sacramento, CA 95834

Dear Mr. Cate:

The California Department of Corrections and Rehabilitation, Division of Juvenile Justice (DJJ), appreciates the opportunity to respond to the results of the Office of the Inspector General's Special Review into the death of Ward *[name removed by the Office of the Inspector General]* on August 31, 2005. The purpose of this review was to examine the circumstances surrounding the August 31, 2005 suicide of Ward *[name removed by the Office of the Inspector General]* at the N.A. Chaderjian Youth Correctional Facility in Stockton.

We agree that there are deficiencies to be addressed. Accordingly, DJJ will develop a comprehensive plan, including specific timelines for implementation, to address the deficiencies identified in your special review. Action has already been taken throughout the DJJ to ensure immediate response in the event that a youth covers their room window and an investigation is underway to determine if there were any violations of policy in this incident. Also, a Departmental Order has been issued enhancing the suicide prevention policy and statewide staff training has been initiated.

The Department has taken immediate action resulting in the following changes at the N.A. Chaderjian Facility since August, 2005:

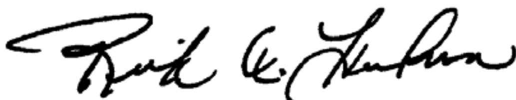
- Intake to the facility was stopped in August 2005 (with limited exceptions for specialized treatment programs) due to escalation of dangerous incidents.
- Routine and extended lockdowns of the general population living units have ended. Since September 15, 2005, there have been only two lockdowns of general population living units. One lasted for nine days, and the second lasted for only two days.
- Reduction in youth-on-youth batteries and group disturbances by 57 percent from September through November (average of 32.5 per month, down to 14 per month).

- Reduction in assaults on staff by 73 percent from September through November (average of 6.2 per month down to 1.6 per month).
- Average living unit population reduced by 31 percent from September through November.
- In September, youth at the facility participated in a career development day with 30 community-based organizations who came to the site to provide services.
- Gang management training has been provided to staff.

Although significant positive changes have occurred at Chaderjian since August, the long-term strategy is to address the systemic issues through the reformation of the statewide DJJ system. This will be accomplished through the phased implementation of the juvenile justice reformation measures incorporated in the Farrell v. Hickman remedial plans that have been filed with the court through December 1, 2005. The reformation measures include: reduction in living unit sizes, treatment programs for all youths including provision of mandated services to all youths, a comprehensive classification system to match youths to the appropriate program based upon risk level and treatment needs, comprehensive standardized assessment and integrated mental health treatment services, establishment of behavior treatment programs with intensive resources to ensure direct treatment services for the most violently disruptive youth, and the establishment of teams to provide dedicated conflict resolution, crisis intervention, and mediation services.

Mr. Bernard Warner, Chief Deputy Secretary of the DJJ, and Mr. Ed Wilder, Director (Acting) of the Division of Juvenile Facilities, are committed to the successful implementation of these reforms. They can be contacted at (916) 323-6001.

Sincerely,



RODERICK Q. HICKMAN
Secretary
California Department of Corrections and Rehabilitation

cc: Bernard Warner
Ed Wilder