

# Report Highlights Oversight of Safety in Secure Care Facilities Office of Juvenile Justice

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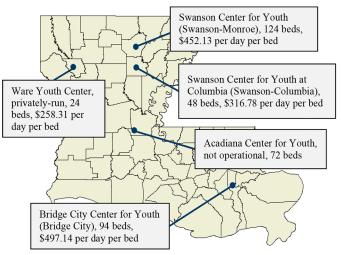
## Why We Conducted This Audit

We evaluated the Office of Juvenile Justice's (OJJ) efforts to ensure its four secure care facilities are safe for its youth and employees. OJJ is responsible for the supervision and custody of adjudicated youth committed to its custody by a judge. Secure care facilities house youth with the most severe level of need and who pose the greatest risk to public safety.

### What We Found

We identified the following issues:

- Staffing challenges, such as high turnover, make it difficult for OJJ to maintain required staff to youth ratios, which affects the overall safety of the facilities. Turnover in secure care facilities has steadily increased since fiscal year 2013.
  Bridge City has the highest overall turnover rate at 62.3%, while Swanson has a 30.6% turnover rate. In addition, secure care facilities are not always compliant with staff to youth ratios as required by the Prison Rape Elimination Act.
- OJJ did not conduct quality assurance audits on secure care facilities from calendar years 2010 through 2015. While OJJ resumed these audits in June 2016, it did not ensure its secure care facilities corrected 205 (51%) of the 404 safety-related action items identified in the audits



**Source:** Prepared by legislative auditor's staff using information from OJJ.

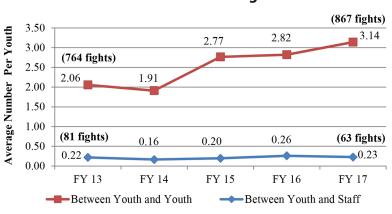
within six months. In addition, 44 items were unresolved for over a year. We found that 51.9% (120 of 231) of safety-related corrective action items identified in 2016 quality assurance audits, and 49.1% (85 of 173) corrective action items identified in the 2017 quality assurance audits were not resolved within six months.

### Secure Care Facilities, Fiscal Year 2017

# **Oversight of Safety in Secure Care Facilities** Office of Juvenile Justice

### What We Found (Cont.)

From fiscal years 2013 through 2017, there has been a 52.7% increase in fights and a 111.3% increase in the use of physical restraints in secure care facilities. OJJ could better use the data it collects on fights and physical restraints to monitor these incidents and give guidance to the facilities on ways to address them. Overall, the number of fights per youth in one year increased 52.7%, from 2.06 per youth (764 total fights) in fiscal year 2013 to 3.14 per youth (867 total fights) in fiscal year 2017. The average number of times physical restraints were used per youth



#### Average Number of Fights per Youth Fiscal Years 2013 through 2017

Source: Prepared by legislative auditor's staff using data from OJJ.

also increased by 111.3% over this same five-year period.

- Since calendar year 2013, the percentage of positive drug screens increased from 2.3% in calendar year 2013 to 9.5% in calendar year 2017. Because OJJ does not collect data on why the drug tests were administered, it cannot determine if there is an increase of drugs being brought into the facility either by staff or visitors, or if youth are using drugs during furloughs. OJJ should collect data on each drug test, including the reason (e.g., suspicion, the youth just returned from a weekend furlough or off-campus trip, etc.) the test was administered.
- While OJJ has reduced the use of room confinement as recommended by best practices, it needs to collect room confinement data in a way that it can be easily monitored and analyzed. While the use of room confinement is lower than it was prior to OJJ implementing a "Reduce the Use" campaign in July 2017, it has increased recently at Bridge City.
- Between fiscal years 2013 and 2017, OJJ did not address 19% of youth grievances within the timeframes set in OJJ policy. In addition, we found that there has been a 23.7% increase in the number of grievances per youth, from 1.26 to 1.56. It is important that OJJ address grievances timely so youth are not deterred from submitting a grievance because of an inefficient process.
- OJJ's procedures for monitoring safety at the Ware Youth Center for female youth are not consistent with its procedures for monitoring the secure care facilities for males. For example, OJJ does not monitor medical care, room confinement, restraints, or grievances at Ware. As a result, female youth are not receiving the same protection and standard of care as males in secure care facilities. We found that Ware uses room confinement areas in its detention center for girls housed in the intensive residential facility, but OJJ does not monitor its use.