Forensic Audit Report

CCSF Juvenile Probation Department

Youth Guidance Center

November, 2011

Auditors

Ron Martinelli, Ph.D., BCFT, CFA, CLS

Anthony Delanda, M.S.

Martinelli & Associates, Justice & Forensic Consultants, Inc. is a recognized member in good standing of the International Law Enforcement Educators and Trainers Association (ILEETA), the American College of Forensic Examiners Institute and Americans for Effective Law Enforcement (AELE).

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Auditors

Ron Martinelli, Ph.D., BCFT, CFA, CLS – is CEO/director of *Martinelli & Associates, Inc.* and is our firm's chief forensic consultant and law enforcement expert qualified in Federal/State Courts. Dr. Martinelli has spent 31 years as a law enforcement training consultant, formerly directed one of the state's Basic Law Enforcement/Corrections/CORE academies and provided law enforcement training to probation agencies through the Board of Corrections, Corrections Standards Authority for 28 years. Dr. Martinelli is a nationally recognized training consultant and a police/corrections Certified Litigation Specialist who has been involved in the training of over 100,000 law enforcement, criminal justice, military and social service professionals representing over 300 national and international agencies. *Martinelli & Associates, Inc.* formerly trained CCSF-YGC staff for over fifteen years.

Anthony Delanda, M.S. – is a Senior Training Consultant and Forensic Analyst in Corrections for *Martinelli & Associates, Inc.* Mr. Delanda is certified as a Master Instructor with the firm and has 18 years of experience working and supervising officers within a large urban juvenile probation corrections institution. He has personally trained thousands of juvenile corrections officers in CA and has consulted internationally. Mr. Delanda has a Masters Degree in Human Resources.

Retention Assignment

In May, 2011, *Martinelli & Associates, Inc.* was contacted by representatives of the CCSF-YGC Peace Officer's Association and their collective bargaining unit SEIU 1021 regarding a request to produce an independent safety audit of the Youth Guidance Center. To that end, we were asked to conduct a site inspection and to review indicia relating to the administration, operations and staffing of the Youth Guidance Center. Among the objectives of the of the safety audit were:

1. Assess the safety of the triage and admittance process for minors being booked into YGC;
2. Observe and identify safety deficiencies regarding day to day operations of YGC;
3. Observe and identify safety deficiencies regarding the operations of the Medical Services Clinic;
4. Observe and identify safety deficiencies with the historic formal/informal customs and practices regarding staffing the Medical Services Clinic;

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5. Observe and identify safety deficiencies regarding the issuance and entrustment of safety equipment and related chattel;

6. If possible, offer forensic findings and opinions regarding whether or not the CCSF and the Youth Guidance Center's administration's historic customs and practices regarding the overall administration of YGC in consideration of our site inspection and a review of discovery are consistent and in compliance with recognized and acknowledged "best practices" within the juvenile corrections industry.

Background:

Currently the City and County of San Francisco Juvenile Probation operates a 132- bed youth detention facility referred to as the Youth Guidance Center (YGC) in San Francisco, CA. Employees of the Juvenile Probation Department are classified as Juvenile Hall Counselors (class 8320). On several occasions in early 2011, Juvenile Hall Counselors claimed that they were unfairly sent home and subsequently disciplined for refusing work assignments in the YGC medical clinic, citing unsafe working conditions pursuant to the current MOU / CBA between SEIU and CCSF Juvenile Probation.

Youth Guidance Center site inspection:

On Friday September 16, 2011, the auditing team conducted a physical plant and personnel inspection of the CCSF – Juvenile Probation – Youth Guidance Center.

During our physical plant/personnel inspection we were accompanied by Chief Probation Officer William P. Siffermann, Allison L. Magee – Director of Administrative Services, SEIU field representative and YGC Counselor/Shop Steward Fred Nelson, President of the YGC peace officers' association.

The following areas were inspected during our visit to the YGC:

1. Booking/ Intake area – LENF personnel sally port areas
2. Pod /cells/ secured living areas, day rooms etc.
3. Medical Clinic
4. Central Control

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5. Security equipment closet/station
6. Visiting area/facility

Sally Port and Booking/Intake Areas:

During the physical plant inspection of the booking/intake sally port area there were several safety concerns/hazards identified.

1. LENF accessible sally port areas had no signage indicating to LENF officers the proper procedure for securing and storing their firearms during the booking / intake process for Juvenile detainees.
2. The booking/intake area also lacked posted signs indicating an admonishment to arrested /detained subjects the potential for defensive force deployment consistent with case precedence outlined in *Tennessee v. Garner*, under "Warnings prior to the deployment of physical defensive force." [1]
3. Other plant deficiencies included "blind" camera video recording areas within the sally port hallways. Entrance and exit doors from the booking/ intake sally port were not viewable by security cameras in the central control area.
4. An inability to visually check the aforementioned areas prior to authorizing entrance and exit electronically from a remote control booth area poses a significant safety/security threat to the officers, juvenile inmates and the public.
5. The perimeter of the sally port area was lacking sufficient security fencing and barriers. There was a lack of deterrent razor/security wire fencing around the upper perimeter areas of the sally port offering attainable escape and evade routes as well.

[1] Tennessee v. Garner, 471 U.S. 1 (1985)

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Pods/Cells/Secured Living Areas/Day Rooms:

The physical plant inspection of the pods, cells and living areas appeared to be clean, safe and consistent with a best industry practice and CA CSA Title 15 guidelines.

Medical Services Clinic:

The physical plant inspection of the medical clinic revealed several significant safety concerns.

1. The clinic area appeared to be cluttered with medical devices that were easily accessible to juveniles upon entry into the clinic. This affords minors an opportunity to arm themselves with various medical devices that they could immediately use to cut, stab and strike medical, corrections staff and each other.

2. The YGC's safety protocol or custom and practice has been to handcuff two minors together with one pair of handcuffs leaving one arm and hand unsecured and placing both juveniles in an awkward physical position exposing all to potential risk of injury from physical transport, movement , falls , disturbances etc. This issue will be addressed further in the personnel inspection report section.

3. The secured area (holding room) that was designed to contain Juveniles for clinic visits was equipped with metal rings attached to a cement bench. This bench area was approximately eight feet wide with metal rings fastened to the top (seating portion) of the cement bench as anchoring devices. These anchoring systems were designed to secure only one hand or wrist utilizing handcuffs. The close proximity between the anchoring devices does little in regards to deterring or preventing inmate v. inmate physical confrontations. CA CSA Title 15 mandates that Juveniles who are handcuffed (physically or mechanically restrained) must be supervised at all times and custodial staff have a duty to protect them from physical harm.

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Central Control:

Our inspection of the central control booth area we identified several safety concerns.

1. The single staff assigned to the control booth area was secured into the control booth area and safety/security staff did not have access to the entry/exit door of the control booth. This posed a significant safety issue in regards to medical emergencies, fire, earthquake, etc.

2. The control booth officer reported on-going radio, video surveillance camera, intercom and electronic control sally-port door problems.

3. The control booth officer reported that not all staff have access to or are required to carry hand-held radios within the institution. This was confirmed through visual observation of counselors within the institution without a radio on their person.

4. The control booth operator also reported that there were on-going electronic issues with the control panel operating electronic lock doors within the institution. A loss of control to electronic doors was considered "on-going" and a common daily occurrence. To further compound issues within the institution there were several critical areas without video surveillance camera coverage where the control booth officer would on occasion lock and unlock sally port doors without visually confirming staff/ personnel. Staff did state that they would attempt to verbally confirm staff via radio prior to controlling the doors; however, due to the lack of, or availability of operational hand-held radios within the institution, this was not always the case. Staff advised that electronic control doors were opened without visual and verbal confirmation of authorized staff/personnel on occasion.

Control Panel

Security Equipment Closet / Station

Within the institution there were closets or security equipment rooms located in the hallways/ corridors between the pod and living areas. These closets were accessible by senior counselors and certain specified personnel. The closets appeared to have a few sets of handcuffs, leg shackles and flex-cuffs as well as others safety items available to staff only in emergency situations. The YGC reported that they staffed no security team personnel to respond to emergency situations.

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It was reported that staff would be deployed to incident areas by senior counselors within pod/living areas and auxiliary support positions with staff "available" for response. The lack of specified and designated security personnel increases staff response times and adds to confusion when responding to emergency situations within the institution.

Visiting & Reception Area

The YGC visiting area was located in a large day room area and staffed with two counselors. During no-visit time frames there were two staff still assigned to this position. There appeared to be no other issues that have not already been addressed in regards to safety and security. There appeared to be no justification to staff an empty visitor reception room with two group counselors. A more appropriate use of manpower would be to not staff the visitor's room with anyone and to staff the room appropriately with two counselors when people are actually engaged in visiting minors.

Staff Inspection

During our inspection of the YGC we encountered and talked to several counselors during the performance of their regularly assigned duties. Several safety / security issues were observed in regards to their individual duty uniforms and safety equipment (chattel).

1. Many officers that we observed appeared to be wearing plain clothes with no semblance of uniformity. The YGC counselors are not issued uniforms with insignia or identification. However, we did see several officers wearing a necklace type display of their department issued badge similar to that of military "dog-tag" chains. This necklace type display of a department issued badge is not commonly found in locked institutions and would be considered a substantial safety/security concern because a violent minor could easily strangle a staff member with the chain. The wearing of loose chains to affix identification badges is not consistent with "best industry" safety practices within most CA institutions.
2. One of the most interesting observations was the lack of a uniform "duty belt" with handcuff cases and radio holsters. Almost every officer observed during our inspection had no duty belt with

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safety equipment. The few staff that did have something similar to a duty belt lacked belt keepers and appropriate emergency access to the safety equipment. The lack of uniformity and "standardized uniform/safety equipment wear standards" exacerbates the pre-existing safety security concerns within the facility.

3. Many staff observed in the performance of their duties had either a different holster system or no holster for their radios and their clothing usually covered their duty belt. This is an unsafe method of wearing safety equipment.

4. A majority of the officers observed had no duty belt on and would hang their handcuffs over their trouser belts unsecured instead of wearing their handcuffs in an approved cuff holster. As experienced arrest, control and restraint tactics instructors we are familiar with what is referred to as a 'best industry" standard and practice regarding the use of mechanical restraints, training and policies within an institutional setting. This severe lapse in safety protocol, training and policy should raise some concerns with CCSF Department Administrators. The use of and entrustment of any mechanical restraint system without properly equipping and training ones employees will expose the agency/staff to potential criminal/civil liability as well as a "foreseeable" risk of injury to juvenile inmates within YGC's custody and control.

5. We found it remarkable that when questioned about various safety and security issues, the Chief Probation Officer was either uninformed or had no knowledge as to why the various safety problems existed.

6. It should also be noted that the Chief Probation Officer has publicly vowed not to entrust his counselors with OC pepper spray within the CCSF –YGC institution.

Staff Competency Training for Entrustments

Our discussions with various YGC group counselors and our prior collective knowledge of the type and level of training historically afforded to the juvenile corrections staff at YGC revealed a number of serious safety problems associated with their entrustments:

1. YGC group counselors who work full-time receive less than the minimum level of training in Use of

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Force and Arrest, Control & Restraint Tactics (ACT).

2. We have reviewed no information to suggest that they receive any credible personal protection or defensive tactics training.

3. We have received no information suggesting that they have ever received any Special Emergency Response Team (SERT) training including cell extractions.

4. The agency does not provide corrections staff with any chemical agents training.

5. We found no evidence that any of the corrections staff had received any training in responses to emotionally disturbed persons (EDPs), or training in Agitated-Excited Delirium.

6. We found no evidence that corrections staff had ever been trained on how to use protective equipment used during room extractions. During our safety inspection we found no protective padded clothing or equipment that would protect corrections staff from weapons or "gassing"[2] during a room extraction.

7. We were informed that additional staff referred to as "part-time, call-back, or recurrent" staff do not receive any training in the aforementioned areas and that any "training" they do receive in "OJT" or "on the job" training from non-certified corrections staffers.

Medical Services Clinic Staffing Matrix and Data Limitations: (Calculated by Anthony Delanda)

The following is a statistical breakdown of the staffing patterns in the YGC clinic from the period of 01/01/10- 09/22/11. It should be noted that there were several days that were missing a staff schedule possibly reflecting lower or higher numbers for staffing in the clinic.

On days when there was more than one officer assigned to the clinic, they were not calculated as two staff unless they were simultaneously serving in the clinic during same/ similar hours. Of specific concern was the lack of a "duty" or "working" schedule produced by CCSF –Juvenile Probation.

[2] "Gassing" throwing liquefied feces/urine and/or other dangerous caustic and/or blood borne pathogenic upon a corrections officer or staff, PC§243.9

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My experience as a Watch Commander / program supervisor in a County operated 600 inmate capacity Juvenile Detention Facility causes me to opine that the YGC administration more probably than not has a schedule that is a "working" document in comparison with the "template" staffing matrix document that they produced for us to review.

The staff matrix documents provided by the YGC administration does not reflect the daily changes, re-assignments and on-going staffing manipulations that are most common in 24 hour detention facilities. There are a number of variables that would significantly impact a staffing schedule/matrix mandating the need for staffing changes throughout a 24 hour shift within the institution. Most commonly occurring incidents that would mandate daily changes on the staffing schedule include the following:

- Staff sick calls;
- Unexpected transportation needs;
- Medical emergencies not capable of being treated within the medical clinics;
- Special programming;
- Educational programming;
- Social service based programming;
- All other support services programming, etc.

Further, the lack of evidentiary documentation provided by YGC's administration severely limits or hinders accurate recording and analyzing historical staffing patterns within the institution. Although my presumptions are speculative, my experience in staffing large detention institutions lends to my overall opinion /credibility in this area.

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Monthly Medical Services Clinic Staffing Statistics

01/01/10- 01/31/10
Of 18 operational days, 1 officer was assigned to the clinic for a total of 13 days. (72.2%).
Of 18 operational days, 2 or more officers were simultaneously assigned to the clinic for 5 days. (27.7%)
02/01/10- 02/28/10
Of 19 operational days 1 officer was assigned to the clinic a total of 13 days (68.4%)
Of 19 operational days 2 or more officers were simultaneously assigned to the clinic for 6 days. (31.6%)
03/01/10- 03/31/10
Of 22 operational days 1 officer was assigned to the clinic for 12 days (54.5%)
Of 22 operational days 2 or more officers were simultaneously assigned to the clinic for 10 days (45.5%)
04/01/10- 04/30/10
Of 22 operational days 1 officer was assigned to the clinic for 15 days (68.2%)
Of 22 operational days 2 or more officers were simultaneously assigned to the clinic for 7 days (31.8%)

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05/01/10- 05/31/10
Of 18 operational days 1 officer was assigned to the clinic for 17 days (94.4%)
Of 18 operational days 2 or more officers were simultaneously assigned to the clinic for 1 day (5.5%)
06/01/10 – 06/30/10
Of 19 operational days 1 officer was assigned to the clinic for 17 days (89.5%)
Of 19 operational days 2 or more officers were simultaneously assigned to the clinic for 2 days (10.5%)
07/01/10-07/31/10
Of 21 operational days 1 officer was assigned to the clinic for 11 days (52.6%)
Of 21 operational days 2 or more officers were simultaneously assigned to the clinic for 10 days (47.4%)
08/01/10- 08/31/10
Of 21 operational days 1 officer was assigned to the clinic for 13 days (61.9%)
Of 21 operational days 2 or more officers were simultaneously assigned to the clinic for 8 days (38.1%)

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09/01/10- 09/30/10
Of 21 operational days 1 officer was assigned to the clinic for 10 days (47.6%)
Of 21 operational days 2 or more officers were simultaneously assigned to the clinic for 11 days (52%)

10/01/10-10/31/10
Of 17 operational days 1 officer was assigned to the clinic for 6 days (35.3%)
Of 17 operational days 2 or more officers were simultaneously assigned to the clinic for 11 days (64.7%)
11/01/10-11/30/10
Of 20 operational days 1 officer was assigned to the clinic for 7 days (35%)
Of 20 operational days 2 or more officers were simultaneously assigned to the clinic for 13 days (65%)
12/01/10- 12/31/10
Of 23 operational days 1 officer was assigned to the clinic for 5 days (21.7%)
Of 23 operational days 2 or more officers were simultaneously assigned to the clinic for 18 days (78.3%)
01/01/11-01/31/11

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Of 22 operational days 1 officer was assigned to the clinic for 7days (32%)
Of 22 operational days 2 or more officers were simultaneously assigned to the clinic for 15 days (68%)
02/01/11-02/28/11
Of 19 operational days 1 officer was assigned to the clinic for 4 days (21%)
Of 19 operational days 2 or more officers were simultaneously assigned to the clinic for 15 days (79%)
03/01/11-03/31/11
Of 22 operational days 1 officer was assigned to the clinic for 5 days (23%)
Of 22 operational days 2 or more officers were simultaneously assigned to the clinic for 17 days (77%)
04/01/11-04/30/11
Of 21 operational days 1 officer was assigned to the clinic for 7 days (33%)
Of 21 operational days 2 or more officers were simultaneously assigned to the clinic for 14 days (67%)

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05/01/11-05/31/11
Of 21 operational days 1 officer was assigned to the clinic for 9 days (43%)
Of 21 operational days 2 or more officers were simultaneously assigned to the clinic for 12 days (57%)
06/01/11-06/30/11
Of 22 operational days 1 officer was assigned to the clinic for 17 days (77%)
Of 22 operational days 2 or more officers were simultaneously assigned to the clinic for 5 days (23%)
07/01/11-07/31/11
Of 20 operational days 1 officer was assigned to the clinic for 9 days (45%)
Of 20 operational days 2 or more officers were simultaneously assigned to the clinic for 11 days (55%)
08/01/11-08/31/11
Of 24 operational days 1 officer was assigned to the clinic for 8 days (33%)
Of 24 operational days 2 or more officers were simultaneously assigned to the clinic for 16 days (67%)

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09/01/11-09/20/11
Of 13 operational days 1 officer was assigned to the clinic for 8 days (46%)
Of 13 operational days 2 or more officers were simultaneously assigned to the clinic for 7 days (54%)

Statistical Data Summary:

Over a period of 8 months (01/01/10 -08/31/10) the YGC administrators and supervisors staffed the clinic with 1 staff member an average of 70 % over an 8 month duration. This is not solely an individual staffing assignment as represented by YGC administrators. The data reflects that at least 30% of the time there were 2 or more staff simultaneously working in the clinic during a designated shift or overlapping shift.

In September, 2010 the data reflects a significant change/shift in the overall staffing patterns in the clinic. The data reflects a shift of YGC administrators staffing the clinic with 2 or more staff simultaneously 62% of the time. The temporal relationship between YGC counselors initiating a practice of citing safety issues pursuant to the CBA/MOU in late 2010 correlates with employees claims in mid 2011 that there was a historic pattern or past practice of staffing the YGC clinic with 2 or more staff simultaneously within a specific shift.

Findings and Opinions

Following a review of the documents and evidence presented to me in this case along with our review of other relevant literature and in consideration of my professional training and experience in corrections practices, I make the following findings and opinions:

1. The summary of statistical data gathered from the staff matrices reflects a definitive staffing pattern of two or more staff assigned to the clinic area beginning

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on 09/01/10- and culminating on 09/22/11. The staffing patterns exhibited in the shift matrices is contradictory to claims made by JPD administrators that historically and as a past practice, there has only been one staff assigned to the clinic per day.

The increase in clinic staffing may be attributed to SEIU noticing CCSF -YGC administrators of potential safety hazards in the clinic; specifically a lack of adequate staffing. The increase may also be viewed as a "good faith" effort on the part of the JPD-YGC Administrators attempting to resolve employee safety concerns.

2. CCSF –JPD Director of Administrative Services, Allison Magee first addressed SEIU and YGC staff concerns in a letter to SEIU representative Margot Reed on December 21st 2010. Ms. Magee stated that through a collaborative process SEIU and JPD administrators met with labor management in an effort to resolve safety concerns within the YGC clinic. Ms. Magee states the following:

(1) During the day shift, one institutional counselor is assigned to the medical clinic.

(2) There is a locked holding room available for placement of youth waiting a medical examination;

(3) JPD policy states that no more than four youth may be in the medical clinic at any given time.

(4) Juvenile Hall management has established that the location of the medical clinic allows for sufficient backup support services for immediate response to emergencies.

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(5) Other areas within Juvenile hall are staffed in a similar fashion including the living units during school hours.

(6) Current staffing is consistent with past practice since new facility opened in 2006.

(7) There have been no incidents or conditions in the medical clinic since the new juvenile hall opened in 2006.

3. The staff matrices statistics indicated that as a "past practice" the CCSF –YGC has assigned more than one staff counselor to the clinic on numerous occasions from 01/01/10 through 09/22/11. The staffing patterns indicate that YGC administrators staffed the YGC clinic with two or more officers 62% of the time beginning in September of 2010 through September of 2011. On many occasions the double staffing pattern was a short two –three hour overlap period in the clinic. However, it is contradictory to the claims made by JPD –YGC administrators touting that as a custom, practice or past practice only one counselor has been assigned to the YGC clinic in an attempt to negate any and all safety concerns of the staff in question.

4. Although the Medical clinic may be adjacent to several locations that may offer immediate back–up support in emergency situations; there is still a legitimate concern for safety not only in the clinic but the entire facility. Upon our inspection of the YGC staff and safety security protocol the staff, physical plant and program had blatant shortcomings in the areas of staff training, policy & procedures and entrustment. The issue here is not whether or not one counselor is placed at a greater safety risk than two counselors, but why the department has failed to remedy historic and noticed deficiencies in these vital areas subjecting all to foreseeable risk. Overall, there appears to be a lack of any semblance of standard operating procedure regarding daily operational tasks, the use of force and the entrustment of defensive weaponry /tactics.

5. According to the current collective bargaining agreement between CCSF –JPD YGC and SEIU local 1021, a counselor under Section VI of said agreement can cite a safety concern within the institution as follows:

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"When a Juvenile Hall counselor has a good faith belief that a work assignment Presents a health and safety risk, that individual should immediately contact the Juvenile Hall Officer of he day (OD) and inform him or her of the health and safety Risk. As the person responsible for the general operations of the shift, the OD serves as the safety officer and will promptly investigate the complaint. The employees must inform the OD of their concern and specify the basis for their claim.

Any employee who refuses to work and doesn't follow this procedure may be deemed insubordinate and disciplined in accordance with the CBA.
While the employee is awaiting the determination of the in-house officer, the employee shall not be required to perform the disputed assignment. However, the OD must make a determination regarding the safety claim before the employee is reassigned or asked to resume his or her regular work. If the OD determines that the assignment in question is safe, the employee may request, but is not guaranteed a reassignment. If the employee refuses to work the assigned shift he or she may be sent home without pay".

In the matter of Maurice Ellis' internal affairs investigation referred to by JPD-YGC as a "3303 government code interview," YGC Administrator Powell stated the following,

"There is not a need for the Safety Officer (Officer of the Day) to respond in each of these medical clinic cases as the OD/Safety Officer makes an overall determination at the beginning of the shift as to the safety concerns".

YGC Administrator Powell and Senior Counselor Rodogno stated the following,

"The OD /Safety Officer confers with the supervisors going off duty, the OD reads the books, the OD examines whether there are any high risk youths that need to be transported and the OD interviews staff about any particular needs or unusual circumstances". [3]

According to YGC administrator Powell, she states in IA testimony that not all safety concerns raised by staff under the current CBA require an individual and separate safety investigation into the matter. This statement and directive to her subordinate supervisorial employees appears to be contradictory to the language set forth in the CBA / MOU, Article VI,

[3] Maurice Ellis- Skelly Hearing Document/ 3303 Government Code Interview; pg 2, ¶ 6.

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"When a Juvenile Hall counselor has a good faith belief that a work assignment presents a health and safety risk, that individual should immediately contact the Juvenile Hall Officer of he day (OD) and inform him or her of the health and safety risk."

As the person responsible for the general operations of the shift, the OD serves as the safety officer and will promptly investigate the complaint.

The current language in the CBA / MOU is specific and does not have a clause included that would exempt an OD / Safety Officer from not investigating each individual employee safety complaint as represented by Ms. Powell. The language appears to be that which would require a thorough examination / investigation into each safety issue brought forth under the CBA/ MOU provisions.

The current CBA / MOU language is also clear in regards to the employee(s) citing Article VI of the CBA and individual articulation of the safety concern to the OD / Safety Officer. The CBA states the following,

"The employees must inform the OD of their concern and specify the basis for their claim".

In the case of Maurice Ellis and others there is a lack of individualized articulation of a "specific basis for their claim." Had these officers cited Article VI of the CBA to better articulate their safety concerns outside of those normally associated with the assignment it would have strengthened their position. However, on several occasions it appears that the safety officer did not diligently investigate or look into these safety matters/issues.

Several of the 3303 Government Code interviews with OD/Safety Officers indicated that the *"employee failed to cite the Article VI of the CBA."* This position by the OD / Safety Officer appears to be adversarial on its face. Any diligent, well trained supervisor within an institution where there is a definite expectation of "foreseeable" risk and potential liability would investigate the reporting of a safety concern by their subordinate employees. To fail to do so is negligence in supervision.

The current explanation offered to YGC administrators/ supervisors by the impacted employees remains a blanket safety concern of inadequate staffing with one person assigned to the medical clinic.

Several of the impacted employees have cited policy and procedures as the rationale for citing Article VI of the CBA versus individualized specific basis for their claim. In our opinion, the letter of law interpretation of the CBA may allow for this type of cite. However, the spirit in

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which it was written calls for a more individualized, reasonable and articulable "good faith" description of the specific safety issue.

In particular, Mr. Ellis' cites YGC policy and procedure of one staff in the medical clinic as the driving force behind his claim of unsafe conditions. However, the YGC policy and procedure to have two staff present within a locked living unit when inmates are unsecured is not uncommon.[4] Although there may be instances when one staff may escort a single inmate or several inmates alone, these transportation and supervision duties away from locked living units and individual cells are commonplace within institutions.

More common support areas offer eye witnesses and surveillance opportunities though halls and sally port areas with video surveillance coverage. The two staff rule on the locked living units and cells protects officers from physical violence, deters escape attempts and panel "take-over's" were inmates can access panels and releasing other inmates within a unit.

CA CSA -Title 15 only mandates that appropriate staffing levels of 1 staff per 10 juvenile inmates be maintained within an institution during "wide awake" supervision hours. JPD-YGC appears to be operating well within the guidelines set forth by the CSA regarding appropriate staffing levels within other areas of the institution.

In reviewing the impacted employees statements and histories we have found that the JPD –YGC has taken a very hard line approach to Article VI of the CBA. This is evident by the administrative disciplinary actions imposed on the impacted employees.

As a best industry practice within similar institutions it has been recognized by Human Resources professionals and Labor Management professionals that a progressive discipline model within these institutions better serves the organization as a whole. Usually, in a progressive discipline model an employee is given an opportunity to remediate initial misconduct or policy violation(s) conduct, if the conduct itself does not rise to a level of severity where immediate removal of the employee is necessary.

In the immediate case of Mr. Ellis, Article VI complicates matters with its language regarding the citing of safety issues. However, due to the language of the CBA and existing safety issues systemic to the

[4] JPD –YGC Policy and Procedures §18.1,II, F , 1 ,i

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YGC it appears that conditions would surmount to a "reasonable person" foreseeing and identifying the same safety issues similar to that as of the impacted employees.

In this case there appears to be no mention of lower level disciplinary or counseling type actions taken to remediate the behavior prior to "suspension." In our opinion, a best industry standard without language as specific as the YGC- CBA would still render a progressive discipline model approach to include verbal counseling, counseling memo, letter of reprimand, suspension and termination; in that specific order. The language of the CBA serves to further mitigate circumstances in favor of the impacted employees under "good faith" interpretation of the language itself not to mention the inherent safety / security issues systemic to the institutional operations, training and chattel entrustment.

6. In summary, the language of Article VI of the existing CBA and systemic safety issues of the JPD – YGC will precipitate further confrontational/adversarial engagements amongst employees and administrators.

   It has been confirmed that contrary to their claims YGC administrators have as an historic "custom and practice" staffed the clinic with 2 staff simultaneously over the periods analyzed. The adversarial nature of both employees and administrators is evident in their engagements over the citing of the CBA.

   We note that employees have failed to more clearly articulate specific/individualized basis for their claims and their supervisors have failed to diligently investigate safety claims pursuant to the CBA.

   In light of a totality of the circumstance analyzed in this case, we find that the multitude of safety issues present within the facility; the custom /practice of staffing the Medical Services Clinic; and the supervisorial negligence in this case offers' support in favor of employees citing "good faith" safety issues within the Medical Services Clinic.

   The fact of the matter is simply that historically and realistically, juvenile correctional facilities are high-risk work areas. In particular, the very nature of the construction of YGC's physical plant as a secure facility underscores that it is most often used to house those minors convicted of violent offenses; or awaiting trial for violent offenses; as well as those minors who are emotionally disturbed among the inmate population who are often within direct contact with staff.

   The past history of the CCSF Juvenile Probation Department's Youth Guidance Center is that it has often been directed by liberal administrators from out of state who are uninformed in the areas of contemporary juvenile corrections and the criminology and socio-criminal demographic of California's juvenile offender population. None of these past "progressive"

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administrators have met with any success in controlling and rehabilitating the offender population at YGC as evidenced by the abnormal turn-over rate of YGC directors.

Over the past twenty years the staff morale at YGC has plummeted, staff confidence in their administrators has eroded; and the numbers of staff on "assault leave" has skyrocketed due to administration's irrational philosophy that has always sought to empower troubled minors while disempowering staff.

It is therefore not only absolutely foreseeable but expected that a minimally trained and poorly equipped staff working in an institution with the safety problems we have determined exist at YGC and exposed to the daily risk of injury or death will eventually experience circumstances which will lead to their serious injury or worse.

In light of the historic safety problems at continue to exist at the Youth Guidance Center despite the fact that a new facility was constructed just a few years ago, the best that the JPD-YGC can do to mitigate risk while enhancing staff's confidence in their ability to protect themselves while attending to their responsibilities to maintain the safety and security of the institution; is to provide an environment for their staff which exposes them to proper direction, supervision, sufficient training, safety equipment and policies that are consistent with recognized "best practices" in juvenile corrections. However, any policies, practices or strategies employed must be well considered and tempered with objective reasonableness, rather than being arbitrary, capricious or retaliatory on its face.

Recommendations for Problem(s) Resolution

1. That the JPD administration drop the current disciplinary charges against the impacted Juvenile Group Counselors who have been suspended for refusing to work alone in the Medical Services Unit in consideration of their failure to follow a practices of progressive discipline; their failure to properly investigate staff's repeated complaints of having to work in an unsafe environment; and their failure to address long standing safety problems associated with the Medical Services Unit;

2. That Juvenile Group Counselors learn how to properly articulate "unsafe work environment" complaints using a standard of "objective reasonableness" and formerly document their safety concerns to supervisors working through a chain of command when working any assignment within YGC. For counselors to continue to work their posts until their supervisors have investigated their concerns and made a determination as to whether or not an assignment is unsafe;

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3. That the JPD administration provide line supervisors with specialized training as to how to properly conduct a safety assessment and form opinions based upon a standard of "objective reasonableness" when forming determinations as to whether or not a particular assignment or post is unsafe for a counselor to work;

4. That the JPD administration, its director and Chief Probation Officer become better informed regarding safety problems within the Youth Guidance Center and take an active role of leadership in addressing long standing safety problems regarding the physical plant; and the lack of safety training and equipment;

5. That the JPD administration provides juvenile corrections staff with appropriate and professional training in all areas of entrustment as discussed in this report. All training provided to YGC Juvenile Group Counselors should be by professionals trainers recognized within the law enforcement and juvenile corrections industry. That all staff who receive said training should also be thoroughly tested for competency in those areas of entrustment;

6. That the CCSF and JPD administration provide all YGC staff with appropriate safety equipment consistent with other juvenile correction facilities in CA; ie. Uniforms, duty belts, handcuffs, restraints, WRAP, chemical agents, protective equipment for room extractions and fights; portable radios, etc.

7. That the safety issues specific to the Medical Services Clinic as addressed in this audit be expeditiously addressed and that it be staffed by two counselors until such time that the identifiable areas of risk have been significantly mitigated to a point where only one counselor may be needed unless otherwise indicated;

8. That the JPD administration develop and implement a staffing matrix for the Medical Services Clinic that is based upon objective needs and not arbitrary or capricious speculation;

9. That the JPD administration meet and confer with YGC staff and their SEIU representatives and retained consultants periodically to ensure a smooth transition to the aforementioned recommendations. That this process towards the final resolution of these problem(s) be completed within 180 days of acceptance of this program;

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10. That a California Board of Corrections, Corrections Standards Authority agency representative periodically review this program and its progress and that this program and its progress be formally documented in the BOC/CSA's annual evaluation of YGC.

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Date: 11-14-11

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