Office of Children and Family Services

Oversight of Juvenile Detention Facilities (Outside New York City)

Report 2023-S-15 | October 2024

OFFICE OF THE NEW YORK STATE COMPTROLLER
Thomas P. DiNapoli, State Comptroller
Division of State Government Accountability

Audit Highlights

Objective

To determine whether the Office of Children and Family Services (OCFS) adequately oversees juvenile justice facilities for youth placed in local detention facilities to ensure they meet State regulations for the health and safety of juveniles and staff. The audit covered the period from October 2018 through January 2024.

About the Program

OCFS' mission is to serve New York's public by promoting the safety, permanency, and well-being of our children, families, and communities. To this end, OCFS, through its Bureau of Juvenile Detention Services, is responsible for the certification, oversight, and monitoring of the State's juvenile detention facilities (local detention facilities). Outside of New York City, OCFS oversees 19 local detention facilities: five specialized secure, six secure, and eight non-secure. These local detention facilities are operated by counties or privately contracted entities that provide supervision and care to the youth in their custody who are awaiting adjudication or disposition of their case by the court. OCFS is responsible for overseeing local detention facilities to provide assurance they are operated in good condition, meet certain environmental and safety standards, and comply with other provisions of OCFS' regulations (Regulations). For example, the Regulations require youth to have a health assessment upon admission and individualized de-escalation plans. Further, under the Regulations, local detention facility staff must meet certain training requirements and log and report incidents (e.g., assault, possession of contraband, self-harm, employee misconduct, restraints of youth) to OCFS.

New admissions to New York's local detention facilities decreased 28% from 1,728 in 2019 to 1,246 in 2021 due to efforts to limit admissions during the COVID-19 pandemic to limit exposure to and spread of the virus. Admissions rose to 1,854 by 2023, or 7% above the 2019 level. Both the average length of stay and the average daily population in local detention facilities increased between 2019 and 2023.

Key Findings

While local detention facilities are meeting the Regulations for health, safety, and physical condition (e.g., sufficient lighting and ventilation, fire safety equipment), we found local detention facilities were not adhering to other requirements of the Regulations. For example:

- Certain assessments and documentation for youth at local detention facilities were not completed as required or within the required time frames. Consequently, this created a risk of missed or delayed opportunities to provide care for physical or mental health issues youth may have when they are admitted to detention facilities. We found there were missing comprehensive medical assessments, which evaluate the physical and mental health of youth entering the facility and missing individualized de-escalation plans. We reviewed files for 368 youth admitted to nine local detention facilities and found:
  - 127 files (35%) lacked support for required assessments or documentation and/or had an assessment or documentation completed late.
  - 82 of the 127 youth with missing or late assessments or documentation were at specialized secure facilities, which have more specific requirements. Of the 82, 57 youth lacked support for a required assessment or documentation, 16 had assessments or documentation completed late, and nine both lacked support for a required assessment and had assessments or documentation completed late.

- In some cases, reviews of restraint incidents were not complete or thoroughly documented. Of the 108 restraint incidents, 22 (20%) were missing certain forms or signatures.
- Of the 227 employees whose training records we reviewed, 93 (41%) were not up to date with required training. Of the 93 employees who were not up to date with training, 84 (90%) worked at secure or specialized secure detention facilities. The most frequently missed training, by 54 employees at these types of facilities, was first aid and cardiopulmonary resuscitation (CPR) training. At one facility, OCFS issued a performance improvement plan—which was in effect from January 2023 through at least October 2023—relating to missed training, but the facility had yet to implement corrective measures.

Key Recommendation

- Clarify, communicate, and, where practicable, standardize procedures for oversight of local juvenile detention facilities to increase assurance that facilities:
  - Comply with Regulations related to completing required assessments, documentation, and staff training.
  - Adhere to policies and procedures for documenting and reviewing incidents involving restraints.
  - Implement corrective actions as directed in the performance improvement plan.

Office of the New York State Comptroller
Division of State Government Accountability

October 21, 2024

Dr. DaMia Harris-Madden
Commissioner
Office of Children and Family Services
52 Washington Street
Rensselaer, NY 12144

Dear Dr. Harris-Madden:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage their resources efficiently and effectively. By so doing, it provides accountability for the tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit entitled *Oversight of Juvenile Detention Facilities (Outside New York City)*. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Division of State Government Accountability

Contents

Glossary of Terms

Term	Description	Identifier
OCFS	Office of Children and Family Services	*Auditee*
Act	Family Court Act	*Law*
CPR	Cardiopulmonary resuscitation	*Key Term*
DRAI	Detention Risk Assessment Instrument	*Key Term*
Incident Form	Form documenting critical or special incidents	*Key Term*
JDAS	Juvenile Detention Automation System	*Key Term*
PIP	Performance improvement plan	*Key Term*
PREA	Prison Rape Elimination Act	*Law*
Regulations	OCFS regulations	*Law*
Restraint Form	Form documenting the use of physical restraint	*Key Term*
RTA	New York's Raise the Age legislation	*Law*
Youth Part	Youth Part within the Criminal Court system created by RTA	*Key Term*

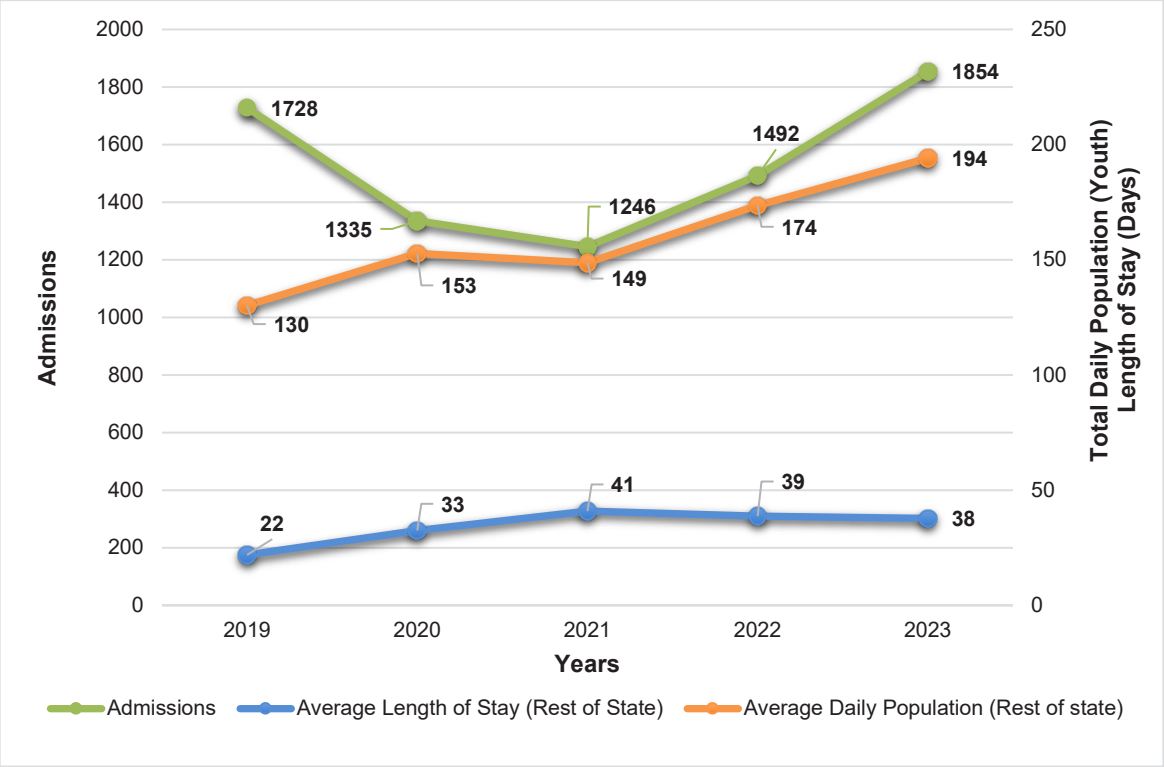
Background

Each year, more than 200,000 youth are admitted to detention facilities in the United States. According to research,[1] pretrial detention can have negative effects on youth outcomes later in life, such as an increase in the chances of not graduating from high school and the likelihood of being arrested, convicted, and incarcerated as an adult. The Office of Children and Family Services' (OCFS) mission is to serve New York's public by promoting the safety, permanency, and well-being of our children, families, and communities. To this end, OCFS, through its Bureau of Juvenile Detention Services, is responsible for the certification, oversight, and monitoring of the State's juvenile detention facilities (local detention facilities). Outside of New York City, OCFS oversees 19 local detention facilities: five specialized secure, six secure, and eight non-secure. These local detention facilities are operated by counties or privately contracted entities that provide supervision and care to the youth in their custody who are awaiting adjudication or disposition of their case by the court.

In New York, provisions in the State's Family Court Act (Act) limit when youth may be placed in a local detention facility. Under the Act, generally, courts may only order youth to a local detention facility if the youth is at a high risk of either not appearing in court or at risk of being re-arrested before their next court date. To help inform these determinations, OCFS developed and requires the use of its Detention Risk Assessment Instrument (DRAI). The DRAI captures information including demographics and the circumstances of the current arrest and contains questions that assess the youth's risk factors. These questions result in a numerical score corresponding to a recommendation to detain the youth or not. There is also a section to explain the reasons for not following the recommendation on the form.

New admissions to New York's local detention facilities (outside New York City) generally decreased from 2019 to 2021 (see figure). According to OCFS officials, there was a concerted effort to limit admissions during the COVID-19 pandemic to limit exposure to and spread of the virus, which contributed to a drop in new admissions by 28% from 1,728 in 2019 to 1,246 in 2021. New admissions began to increase after 2021 and were back above the 2019 level by 2023. The pandemic also initially contributed to a rise in the length of stay for detained youth—almost doubling in 2021 from pre-pandemic levels. OCFS officials noted that court closures led to case backlogs during the pandemic, increasing the length of stay, which has remained elevated since then. The average daily population at detention facilities overseen by OCFS has increased since 2019 and, during 2023, the average daily population reached 194.

1 https://www.cato.org/research-briefs-economic-policy/pretrial-juvenile-detention



Enacted in April 2017, New York's Raise the Age (RTA) legislation raised the age of criminal responsibility to 18 years of age, with the aim of ensuring that New York youth who commit non-violent crimes will receive age-appropriate housing and programming to lower their risk of re-offense. RTA was phased in over time and took effect for 16-year-old offenders on October 1, 2018, and was fully implemented on October 1, 2019, when it took effect for 17-year-old offenders. Among other changes, RTA:

- Prohibited 16- and 17-year-old offenders from being held in adult jails and prisons
- Created the Adolescent Offender category of offender, covering 16- and 17-year-olds charged with felony crimes
- Created the Youth Part within the Criminal Court system (Youth Part) to be presided over by specially trained family court judges

Under RTA, the newly created Youth Part was tasked with handling the most serious youth offender cases: felony cases for 16- and 17-year-olds and violent felony cases for youth age 13–15 years who aren't transferred to family court. Youth convicted and sentenced to confinement in the Youth Part cannot be placed in adult jails or prisons. Specialized secure facilities were created under RTA and are intended to exclusively serve adolescent offenders: youth who are 16 or 17 years old and charged with a felony.

OCFS regulations (Regulations) govern local detention facilities, which fall into three categories: non-secure facilities, secure facilities, and specialized secure facilities. While some regulatory requirements apply to all local detention facilities, others apply only to certain types of local detention facilities. The regulatory provisions applicable to specialized secure facilities contain more specific and detailed requirements for assessments and documentation that must be completed when a youth is admitted. Certain requirements are triggered by how long a youth is detained. For example, the Regulations require specialized secure facilities to complete a comprehensive health assessment within 3 days (72 hours) of admission, which includes a physical exam and reviews of the youth's medical history, and any illnesses and symptoms. The Regulations also require specialized secure detention facilities to:

- Prepare an individualized plan that documents recommended de-escalation techniques and notes any physical restraint restrictions within 10 days of admission.
- Provide dental care to each youth, including a dentist visit within 60 days of intake.

Regarding secure and non-secure facilities, the Regulations require all youth to have a health assessment that includes a physical exam and review of the youth's health history within 3 days (72 hours) after admission to the facility.

The Regulations also require local detention facility employees to report unusual or serious events (incidents) like assaults, sexual abuse, employee misconduct, contraband, death, or the use of physical restraint to OCFS. While incidents must be reported to OCFS using the Juvenile Detention Automation System (JDAS), each facility has its own policies, procedures, and forms to record and track incident information. Under the Regulations, the record retention requirement for youth files at specialized secure facilities is 10 years—for secure and non-secure it is until the youth is 18 years old.

Incident information is captured on forms unique to each facility, generally known as critical or special incident forms (Incident Forms). Incident Forms collect information such as the incident date, youth and staff involved, type of incident, description of incident, follow-up, and notifications. The Incident Forms also require a signature from the staff involved and facility director. In addition, each facility has a policy requiring local detention facility staff to also complete a physical restraint form (Restraint Form) when a youth is restrained.

Regulations require employees at local detention facilities to receive training in a variety of areas, and the different types of facilities have different requirements for the employees who work there. The Regulations for specialized secure facilities are more detailed on the type of training required than those for the other types of facilities. The training that specialized secure facilities must provide to their staff includes instruction in key areas such as:

- Behavior management
- Mandated reporting

- Universal precautions and bloodborne pathogens
- Safety and security procedures
- Emergency response, including first aid and cardiopulmonary resuscitation (CPR)
- Prison Rape Elimination Act (PREA) guidelines

Regulations for non-secure facilities include training requirements for safety and security procedures and techniques of group and child management, including crisis intervention. While most of the training is required annually, the frequency can vary by facility. For example, certain facilities require first aid and CPR every 2 years.

OCFS staff are responsible for overseeing local detention facilities to provide assurance they are operated in good condition, meet certain environmental and safety standards, and comply with other Regulations that govern those facilities. OCFS conducts regular site visits (monthly for specialized secure and secure facilities but less frequently for non-secure facilities) to local detention facilities to assess facility compliance with the Regulations. OCFS staff use checklists as a tool to test facility compliance with the Regulations. If necessary, OCFS issues a performance improvement plan (PIP) to the facility identifying deficiencies that need to be corrected.

Audit Findings and Recommendations

While we found local detention facilities are meeting State standards and Regulations for the health and safety of youth and staff as well as required physical conditions (e.g., sufficient lighting and ventilation, fire safety equipment), we found weaknesses with other aspects of OCFS' oversight. For example, local detention facilities did not have evidence to support that certain assessments and documentation were completed as required or within the required time frames. Consequently, this created a risk of missed or delayed opportunities to provide care for physical or mental health issues youth may have when they are admitted to local detention facilities. This risk is further compounded by an increase in the average length of stay for youth in these facilities.

We also identified restraint incidents that were lacking sufficient support to determine that a complete review of the events had been conducted. Further, we found some direct care staff were not current with training requirements despite OCFS' reviews of facilities' training records and issuance of a PIP. It is important for staff at the facilities to be adequately trained, particularly in areas of emergency response and health/safety, to respond to emergencies and incidents and ensure the safety of their youth. OCFS and facility officials cited staff turnover and the COVID-19 pandemic as contributing factors to the missing assessments, documentation, and training.

At the nine facilities we visited, physical conditions within living quarters, bathrooms, common areas, and medical services were adequately maintained, clean, and in functioning condition.

Assessments and Screenings

Youth who enter detention facilities often have a history of, or are at higher risk for, physical and mental health problems. According to a publication from the American Academy of Pediatrics,[2] multiple studies have been performed that have found youth in the juvenile correctional system have higher rates of health issues than those in the general population. For example, the publication cited that, in some facilities, over 90% of the youth required dental care, with issues ranging from untreated decay to tooth or jaw fractures. Further, incarcerated youth have higher rates of mental health and substance use problems, with documented rates that exceed those of the general adolescent population. Identifying and addressing issues with youth early is increasingly important when dealing with youth who suffer from substance use and co-occurring disorders (simultaneous presence of both a mental health and a substance use disorder).

Due to the risks associated with this population, it is important to ensure youth are receiving required physical and mental health assessments in a timely manner so they can obtain necessary treatment and services. When initial assessments—especially those related to the youth's health—are not completed within prescribed time frames or at all, there is a risk of missed or delayed opportunities to provide care for physical conditions (e.g., vision or dental concerns, diabetes) or mental

2 https://publications.aap.org/pediatrics/article/128/6/1219/31060/Health-Care-for-Youth-in-the-Juvenile-Justice?autologincheck=redirected

health issues (e.g., depression, anxiety) youth may have when they are admitted. This risk is further compounded by an increase in the average length of stay for youth in these facilities.

Incident data for local detention facilities (outside New York City) between January 2019 and December 2022 shows an increase in incidents like controlled contraband and self-harm. In 2019, there were no incidents of controlled contraband (drugs), but there were 14 incidents in 2022. During the same period, incidents of self-harm at local detention facilities were up 65% (from 63 to 104) while those classified as attempted suicide were up 33% (from 27 to 36).

We identified instances of required assessments and documentation that were completed late or lacked evidence of completion at all. Of the files reviewed for 368 youth who entered nine local detention facilities between October 2018 through October 2023, 127 (35%) had missing (92), late (26), or both missing and late (9) admission records or required documentation.

We found 45 of 127 (35%) youth with missing or late assessments or supporting documentation were detained at secure or non-secure facilities. Of the 45 youth, 35 were missing evidence of the health assessment and 10 received the assessment after the required 72 hours. The late medical assessments ranged from 1–14 days overdue.

Notably, 82 of the 127 (65%) youth with missing or late required assessments or documentation were detained at specialized secure facilities. The most frequently missing documentation was evidence of a dental exam, which was missing for about 85% of the youth. Individualized de-escalation plans (designed to prevent potential violence) were missing for 38 of 88 (43%) youth. The comprehensive medical assessment was not completed within the required 3 days (72 hours) for 20 of the 115 (17%) youth upon admission at specialized secure facilities. For one youth, the assessment wasn't done for nearly 4 months (118 days). The other assessments were on average 8 days late and ranged from 1–89 days late. See Table 1 for the breakdown of missing and late assessments and documentation at specialized secure facilities.

Table 1 – Missing and Late Required Assessments and Documents at Specialized Secure Facilities

Type of Assessment or Documents (*in order of when it's required)*	Total Youth Reviewed for Each Requirement	Number of Youth Missing Records	Percent Missing	Number of Youth With Late Assessment or Screenings	Percent Late
Admission Assessment Instruments	139	4	3%	0	0%
Comprehensive Medical Assessment (length of stay at least 3 days)	115	20	17%	20	17%
Individualized De-escalation and Physical Restraint Plans (length of stay at least 10 days)	88	38	43%	5	6%
Dental Examination (length of stay at least 60 days)	48	41	85%	3	6%
Total Missing or Late*		**103**		**28**	

*Some of the 82 youth had multiple instances of missing or late assessment documentation.

Local detention facility officials acknowledged records were missing or late for a variety of reasons, including staff turnover and vacancies in key positions, such as the Program Director and Program Manager roles, and challenges retaining specialized service providers like dentists. Another reason officials cited for missing records was that they resided with third-party contractors. OCFS officials stated that all providers have processes to obtain prior records. However, while records may not have been kept on site and may not have been readily available at the time of our site visits, we worked with facility staff for several months to obtain the missing documentation, and the facility was still unable to provide the information.

Further, staff at certain local detention facilities stated they were not familiar with the need to retain certain records. For example, officials at two facilities did not have all the required individualized de-escalation and physical restraint plans because they were unaware of the requirement to keep the plans on file.

OCFS officials also noted that, during the COVID-19 period, it was difficult for the facilities to get medical-related requirements completed because of the reluctance of providers to come into the facilities. Of the 368 youth records we reviewed, 113 were admitted during the height of COVID-19 (March 1, 2020 through March 31, 2022). Of these 113 youth, 51 (45%) had records with missing or late items. Of the 127 youth with missing or late required assessments or documentation, youth admitted during the height of COVID-19 accounted for 40% of the total.

While OCFS conducts regular site visits to the local detention facilities to assess facility compliance with the Regulations, staff have discretion over what sections of the Regulations are reviewed and there is no guidance on how those sections should be selected. During calendar year 2023, OCFS staff included a review of admission records at six of the nine facilities that we also visited. OCFS did not report any issues related to youth files as a result of those reviews. However, we determined

about 35% of the youth files we reviewed at facilities where OCFS also conducted a review had missing or late admission records.

Review of Restraint Incidents and Staff Training

Restraint Incidents

Physical intervention with youth should be minimized to the extent possible and restraints used only to contain acute physical behavior that clearly indicates the intent to inflict physical injury upon oneself or others or otherwise jeopardizes the safety of any person. Staff must use only the amount of force necessary to stabilize the situation. The purpose of conducting a review of each restraint incident and completing additional documentation of the event is to ensure restraints are handled appropriately and reduce the likelihood that problems, conflicts, or behaviors will escalate to a level that requires physical intervention in the future.

We identified restraint incidents that were lacking sufficient support to determine that a complete review of the events had been conducted. In some cases, the incidents were missing Restraint Forms. In others, the subsequent review and Incident Forms were not approved by the facility director or staff.

We reviewed 108 restraint incidents at nine local detention facilities occurring between January 2019 and October 2023. Of the 108 restraint incidents, 22 (20%) were missing certain forms or signatures.[3] We found:

- 18 (17%) were missing the Restraint Forms.
- 5 (5%) were missing the Incident Forms.
- 5 (5%) were missing the required signatures of staff or the facility director on Incident Forms.

While these 22 incidents were missing the required forms and/or signatures at the local detention facilities, information on these incidents was recorded electronically in JDAS. Facility officials attributed the missing forms and approvals to staffing and turnover, which affected facilities' ability to fully conduct and document incident reviews. While JDAS captures similar information to what is on the Incident Reports, having those reports on site provides key support that the incident information was signed by facility staff and reviewed by the director.

During calendar year 2023, OCFS reviewed incidents at each of the nine facilities we visited at least once. OCFS also noted incidents were missing sufficient support in certain instances.

3 Some restraint incidents were missing more than one form and/or signature.

Training Requirements

Training and education help increase the knowledge, skills, and competency of staff. It is important for local detention centers to ensure staff are up to date on required training so staff may provide a safe environment for the youth in their care. However, we found local detention facilities did not ensure that direct care staff were current with certain required training.

We reviewed training records for 227 direct care employees[4] at nine local detention facilities to assess compliance with certain training requirements in the Regulations. We found 93 (41%) employees were not up to date with at least one required training course during calendar year 2023. Of the 93 employees who were not up to date with training, 84 (90%) worked at secure or specialized secure detention facilities. The most frequently missed training, by 54 employees at these types of facilities, was first aid and CPR training. The other training courses missed by the most employees were behavior management (25) and PREA (14). Nine employees (10%) who were missing training worked at non-secure facilities where the most frequently missed training was emergency preparedness (6). The other missed trainings were behavior management and mandated reporting. See Table 2 for a breakdown of the missing training requirements.

Table 2 – Missing Training Requirements

Training Course	Number of Employees Missing Training at Specialized Secure and Secure Facilities	Number of Employees Missing Training at Non-Secure Facilities
Emergency Response including First Aid and CPR (Specialized Secure)/Emergency Preparedness (Non-Secure)	54	6
Behavior Management	25	2
PREA*	14	N/A
Mandated Reporting	9	1
Health and Safety*	7	N/A
Universal Precautions and Bloodborne Pathogens*	4	N/A
Totals	113**	9

*Courses required only for specialized secure facilities under the Regulations.
**Some employees were missing more than one training.

Direct care staff play an important role in the safety of youth. Should an emergency arise, it is critical that employees have been trained for, are familiar with, and understand their roles during those situations. Therefore, the lack of timely staff training, particularly in areas such as first aid, CPR, and emergency preparedness, increases risks to both staff and youth at the facilities should an unpredictable event occur.

4 The specialized secure and secure facilities visited during our audit were co-located and shared staff between them. For testing and reporting purposes, we measured compliance with staff training against the more specific requirements for specialized secure facilities because staff may work in either type of facility.

During calendar year 2023, OCFS reviewed employee training at three of the facilities we included in our site visit review. OCFS issued a PIP to one facility directing them to complete mandatory training, including first aid and CPR training. OCFS did not issue a PIP to the other facilities, although we found they both had employees who were not up to date on required training. The PIP was in effect from January 2023 through at least October 2023, but the facility had yet to implement corrective measures.

Local detention facility officials acknowledged training was not up to date for a variety of reasons including a lack of trainers (specifically for CPR training) or notification errors from training systems that caused certain trainings to be missed. At some facilities, officials were aware training was overdue and noted they had scheduled classes for after our visits.

Recommendation

1. Clarify, communicate, and, where practicable, standardize procedures for oversight of local juvenile detention facilities to increase assurance that facilities:
    - Comply with Regulations related to completing required assessments, documentation, and staff training.
    - Adhere to policies and procedures for documenting and reviewing incidents involving restraints.
    - Implement corrective actions as directed in the PIP.

Audit Scope, Objective, and Methodology

The objective of our audit was to determine whether OCFS adequately oversees juvenile justice facilities for youth placed in local detention facilities to ensure they meet State regulations for the health and safety of juveniles and staff. The audit covered the period from October 2018 through January 2024.

To accomplish our objective and assess related internal controls, we reviewed State laws, regulations, and local detention facility policies; interviewed OCFS and facility officials; observed facility conditions; and examined OCFS and facility records.

We used a non-statistical sampling approach to provide conclusions on our audit objective and to test internal controls and compliance. We selected both judgmental and random samples. However, because we used a non-statistical sampling approach for our tests, we cannot project the results to the respective populations, even for the samples. Our samples, which are discussed in detail in the body of our report, include:

- A judgmental sample of nine (of 19) local detention facilities outside of New York City based on the type of facility and number of incidents reported, to observe the conditions at each facility and test compliance with selected portions of the regulations.
- A judgmental sample of 301 incidents (of 4,083) selected based on the facility where the incident occurred, the type of incident, the length of time to report the incident, and how recently it occurred, to assess whether the incidents were reported accurately and followed reporting procedures in the Regulations. We performed additional testing for 108 incidents (of 301) involving the physical restraint of youth to determine whether these incidents had the appropriate documentation completed, reviewed, and filed according to the Regulations and facility policies.
- We reviewed training records for all current direct care staff (227 individuals) at the nine facilities at the time of our facility visits (occurring between December 2023 and January 2024) to determine whether staff completed training requirements within time frames required by the Regulations.
- A random sample of 368 youth (of 2,883), representing approximately 13% of the admissions at the nine facilities, to test whether staff completed the required admission screening and documentation within the established time frames for those youth.

We obtained youth incident and intake data from JDAS. We assessed the reliability of that data by reviewing existing information, interviewing officials knowledgeable about the system, and tracing to and from source data. We determined that the data from this system was sufficiently reliable for the purposes of this report. Certain other data in our report was used to provide background information. Data that we used for this purpose was obtained from the best available sources, which were identified in the report. Generally accepted government auditing standards do not require us to complete a data reliability assessment for data used for this purpose.

Statutory Requirements

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. These duties could be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our professional judgment, these duties do not affect our ability to conduct this independent performance audit of OCFS' oversight and administration of oversight of juvenile justice facilities.

Reporting Requirements

We provided a draft copy of this report to OCFS officials for their review and formal comment. We considered their response in preparing this final report and have included it in its entirety at the end of the report. In their response, OCFS officials generally agreed with our recommendation and described actions that are already underway or planned to address it.

Within 180 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Office of Children and Family Services shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendation contained herein, and where the recommendation was not implemented, the reasons why.

Agency Comments

NEW YORK STATE | Office of Children and Family Services

KATHY HOCHUL
Governor

DAMIA HARRIS-MADDEN, Ed.D., MBA, M.S.
Commissioner

July 31, 2024

Andrea C. Miller
Executive Deputy Comptroller
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Re: Audit 2023-S-15 Response to the Draft Report

Dear Executive Deputy Comptroller Miller:

The New York State Office of Children and Family Services (OCFS) has prepared this letter in response to the Office of the State Comptroller's (OSC) July 2024 Draft Report for Audit 2023-S-15. OSC's stated objective of the audit was to determine if OCFS adequately oversees juvenile justice facilities for youth placed in local detention facilities to ensure they meet State regulations for the health and safety of juveniles and staff. The audit covered the period from October 2018 through February 2024.

OCFS is grateful for the acknowledgement from OSC that local detention facilities overseen by the OCFS Division of Youth Development and Opportunities for Success (YDAPS) are meeting state standards and regulations for the health and safety of youth and staff and that the facilities meet the required physical conditions (e.g., sufficient lighting and ventilation, fire safety equipment).

OCFS respectfully contextualizes the audit key findings and recommendations of OSC, as a significant portion of this audit applied to a timeframe when the state, counties and country dealt with the unprecedented and dramatic impact of the COVID-19 pandemic, as well as the collateral impact of COVID-related difficulty in finding adequate staff and services within the facilities--a reality that continues today. Governor Hochul has recognized the impact by providing support to local detention facilities to offer incentives, increase salaries, and enhance programming. OCFS is appreciative that OSC has referenced the impact of COVID-19 on some of the key findings.

OSC Key Finding #1:

Certain assessments and documentation for youth at local detention facilities were not completed as required or completed within the required time frames. Consequently, this created a risk of missed or delayed opportunities to provide care for physical or mental health issues youth may have when they are admitted to detention facilities. We found missing comprehensive medical assessments, which evaluate the physical and mental health of youth entering the facility and missing individualized de-escalation plans.

* * * * *

We identified instances of required assessments and documentation that were completed late or lacked evidence of completion at all. Of the files reviewed for 368 youth who entered nine local detention facilities

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between October 2018 through October 2023, 144 (39%) had missing (110), late (19), or both missing and late (15) admission records or required documentation.

OCFS Response: OCFS takes seriously its responsibility of oversight and monitoring facility adherence to state regulations and standards. As noted above, staffing availability was negatively impacted by the pandemic during the relevant period, including clinical/medical staff responsible for the assessments. Additionally, for a portion of the period reviewed, some facilities utilized contracts with external medical and/or mental health providers but were no longer under contract at the time of the audit, making it difficult to access historical files. Further, medical and mental health evaluations are completed on an ongoing basis, not only at admission, especially when the youth may not be willing to engage in assessments despite the best efforts of staff.

OSC Key Finding #2:

We identified restraint incidents that were lacking sufficient support to determine that a complete review of the events had been conducted. In some cases, the incidents were missing Restraint Forms. In others, the subsequent review and Incident Forms were not approved by the facility director or staff.

We reviewed 108 restraint incidents at nine local detention facilities, occurring between January 2019 and October 2023. Of the 108 restraint incidents, 22 (20%) were missing certain forms or signatures.

OCFS Response: OCFS recognizes the importance of thorough documentation of incidents, particularly those that involve a restraint. As acknowledged by OSC, the primary system for incident reviews is the Juvenile Detention Automated System (JDAS) and each of the 22 incidents missing documentation was recorded electronically in JDAS. OCFS detention specialists receive a daily feed of all incidents and conduct follow up with the facilities; this ensures that even if a facility failed to document its review of incidents in accordance with its internal policies, the incident was reported to OCFS and OCFS can respond appropriately to these incidents.

OSC Key Finding #3:

We reviewed training records for 227 direct care employees at nine local detention facilities to assess compliance with certain training requirements in the Regulations. We found 93 (41%) employees were not up to date with at least one required training course during calendar year 2023. Of the 93 employees who were not up to date with training, 84 (90%) worked at secure or specialized secure detention facilities. The most frequently missed training, by 53 employees at these types of facilities, was first aid and CPR training. The other training courses missed by the most employees were behavior management (25) and PREA (14). Nine employees (10%) who were missing training worked at non-secure facilities where the most frequently missed training was emergency preparedness (6). The other missed trainings were behavior management and mandated reporting.

OCFS Response: OCFS recognizes that staff training is critical for the detention operating agencies to ensure safe and healthy environments for youth. OCFS notes that during the period under review, there were very few CPR trainers available to come into the environment and provide training due to COVID restrictions. Additionally, staffing shortages and staff members being unable to work due to COVID exposure exacerbated the difficulties in achieving all the required trainings timely. The ending of COVID mandatory 10-day quarantine and increases in facility staffing has helped mitigate this issue.

OSC Recommendation:

Clarify, communicate, and, where practicable, standardize procedures for oversight of local juvenile detention facilities to increase assurance that facilities:

- *Comply with Regulations related to completing required assessments, documentation, and staff training.*
- *Adhere to policies and procedures for documenting and reviewing incidents involving restraints.*
- *Implement corrective actions as directed in the PIP.*

OCFS Response:

- OCFS is updating its detention regulations. OCFS will propose to implement a new oversight instrument that will standardize oversight review practices across the state.
- OCFS will be retraining all detention oversight staff on conducting site visits and record reviews, to ensure standard practice across facilities. As part of this retraining, OCFS is developing instruments to standardize the process. OCFS intends to implement this new process by September 2024, with oversight staff maintaining tracking charts to measure compliance with regulations, including:
  - youth documentation and assessments
  - facility policies
  - documentation of reportable incidents
  - completion of PIPs
  - personnel records, including training compliance.
- OCFS, in collaboration with detention agencies, is drafting universal intake assessment requirements to be utilized by detention providers. This will operationalize the requirements for intake in one document. OCFS anticipates this will be implemented before the end of 2024.
- OCFS has updated its PIP tracking to identify inadequate follow-up by facilities and when further action is needed.
- OCFS has been monitoring staffing levels in detention facilities since 2020 and using that information to extract trends for insight into any difficulties that negatively impact staff training compliance.

Conclusion:

OCFS will review OSC's findings and recommendations with all detention oversight staffs and the facilities as part of its efforts to better provide services to youth and support facility staffs. With that, OCFS anticipates an improved and more consistent practice, as well as enhanced outcomes for youth.

Thank you for meeting with OCFS to discuss the report and for the opportunity to respond to provide clarity on OCFS's commitment to monitoring so that youth in local custody are provided with the services and supports to be safe and healthy. Please contact me with any questions regarding this response.

Sincerely,

Dr. Nina Aledort
Deputy Commissioner
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