

# Office of Children and Family Services

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## Oversight of Juvenile Justice Facilities

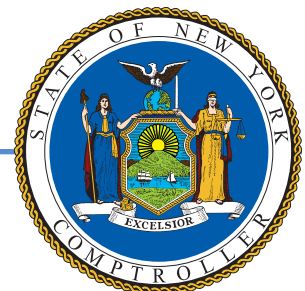
Report 2022-S-13 | April 2024

OFFICE OF THE NEW YORK STATE COMPTROLLER

Thomas P. DiNapoli, State Comptroller

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Division of State Government Accountability



# Audit Highlights

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## Objective

To determine whether the Office of Children and Family Services adequately operates juvenile justice facilities for court-placed youth to ensure they meet State standards and regulations for the health and safety of juveniles and staff. The audit covered the period from October 2018 through August 2023.

## About the Program

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. Toward this end, OCFS, through its Division of Juvenile Justice and Opportunities for Youth (DJJOY), is responsible for the operation and oversight of nine State-run residential juvenile justice facilities that serve court-placed youth. The nine facilities include three secure facilities, five limited-secure facilities, and one non-secure facility. OCFS must ensure that these facilities are operated in good condition and in compliance with the DJJOY Policy and Procedure Manual, conduct regular fire safety inspections, have an emergency plan, maintain sanitary conditions, and provide health screenings upon admission. Further, OCFS must ensure that facility staff are properly trained and that, when incidents (e.g., assault, possession of contraband, self-harm, employee misconduct, restraints of youth) occur, facilities log and report them as required.

From 2018 to 2022, the number of youth in DJJOY facilities increased by nearly 74%, due in part to new legislation that contributed to an increase in youth placements in DJJOY facilities. The three secure facilities experienced an increase in their youth population of more than 200% from 2019 to 2022. As the number of youth at secure facilities rose, so did the number of incidents, increasing by nearly 84%. During this same time, DJJOY facilities – secure facilities in particular – experienced staffing shortages and large increases in overtime costs.

## Key Findings

While we found DJJOY facilities are meeting State standards and regulations for the health and safety of youth and staff and meet required physical conditions (e.g., sufficient lighting and ventilation, fire safety equipment), we found weaknesses in several aspects of OCFS' operation of DJJOY facilities. For example:

- OCFS has not ensured that certain admission assessments and screenings, including health-related assessments, were completed and documented as required or were done within the required time frames, creating the risk of missed or delayed opportunities to identify or provide care for physical health conditions (e.g., vision or dental issues, diabetes) or mental health concerns (e.g., depression, anxiety) youth may have when admitted to DJJOY facilities. Further, these assessments and screenings can be vital because youth entering juvenile justice programs often have a history of medical neglect. We reviewed admission files for 101 youth at six DJJOY residential facilities and found:
  - 53 (52%) files lacked documentation that at least one of the required admission assessments or screenings – including those required to be done within the first week after admission – was completed. For example, we found missing medical admission checklists (which document that all the required medical assessments were completed on time) and missing history and systems review forms (used to document preliminary interviews with youth about their physical and mental health).

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- 44 (44%) of the 101 youth had at least one assessment or screening, such as the comprehensive medical assessment, completed late, including one youth's medical assessment (which is required to be completed within 7 days of admission) that wasn't done for nearly 9 months.
  - OCFS did not ensure that all direct care staff were current with the training to be authorized to restrain youth. We reviewed training records for 162 employees involved in restraint incidents at six DJJOY residential facilities and found:
    - 87 (54%) employees were not up to date with the training required to be authorized to restrain youth. For example, in one case, an employee was involved in a restraint incident in February 2023, but their CPR/first aid training had been expired since March 2020 – nearly 3 years before. In another instance, an employee involved in a different incident in February 2023 was overdue on their crisis prevention and management training by more than 2 years.
    - 95 (59%) employees had not completed their annual Ready Emergency Data Book (emergency procedures) refresher course, including one employee who last had the training nearly 3 years earlier. As a result, employees may not be familiar with or understand their roles in the event of an emergency.
  - OCFS did not always ensure the reviews of incidents were complete or thoroughly documented. We identified restraint incidents that were missing support that a complete review of the events had been conducted. For example, we reviewed restraint packets for 106 incidents at six DJJOY facilities and found:
    - 22 (21%) were not recorded in the restraint log at the facility, as required.
    - 9 (8%) were missing the Restraint Monitoring form.
    - 6 (6%) were missing the Administrative Review form.
    - 5 (5%) Administrative Review forms were missing evidence of approval from the facility director (or designee).

## Key Recommendation

- Review current administrative procedures and training curriculum and, where practicable, implement changes to enable staff to, at a minimum:
  - Complete admission assessments and screenings on time,
  - Meet training requirements, and
  - Complete restraint incident review and record-keeping requirements.



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

April 3, 2024

Suzanne E. Miles-Gustave, Esq.  
Acting Commissioner/Executive Deputy Commissioner  
Office of Children and Family Services  
52 Washington Street  
Rensselaer, NY 12144

Dear Acting Commissioner Miles-Gustave:

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 Justice Facilities*. 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

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- Glossary of Terms** ..... **5**
- Background** ..... **6**
- Audit Findings and Recommendations** ..... **11**
  - Admission Assessments and Screenings ..... **11**
  - Staff Training and Restraint Incident Reviews ..... **13**
  - Recommendations ..... **15**
- Audit Scope, Objective, and Methodology** ..... **16**
- Statutory Requirements** ..... **17**
  - Authority ..... **17**
  - Reporting Requirements ..... **17**
- Agency Comments** ..... **18**
- State Comptroller’s Comment** ..... **22**
- Contributors to Report** ..... **23**

# Glossary of Terms

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<b>Term</b>	<b>Description</b>	<b>Identifier</b>
OCFS	Office of Children and Family Services	<i>Auditee</i>
CPM	Crisis prevention and management course	<i>Key Term</i>
CPR	Cardiopulmonary resuscitation	<i>Key Term</i>
DJJOY	Division of Juvenile Justice and Opportunities for Youth	<i>Division</i>
DJJOY facilities	The nine State-run residential juvenile justice facilities that serve court-placed youth	<i>Key Term</i>
FTE	Full-time equivalent	<i>Key Term</i>
Manual	DJJOY Policy and Procedure Manual	<i>Policy</i>
R.E.D. Book	Ready Emergency Data Book	<i>Key Term</i>
RTA	New York's Raise the Age legislation	<i>Law</i>
Youth Part	Youth Part within the Criminal Court system created by RTA	<i>Key Term</i>

# Background

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According to a study published in the *Journal of the American Medical Association*,<sup>1</sup> incarcerating youth in adult correctional facilities exposes them to conditions that may adversely affect psychological and physical health. In New York, youth are generally placed in a residential juvenile justice facility as an alternative. 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. Toward this end, OCFS, through its Division of Juvenile Justice and Opportunities for Youth (DJJOY), is responsible for the operation and oversight of nine State-run residential juvenile justice facilities that serve court-placed youth. The nine facilities include three secure facilities, five limited-secure facilities, and one non-secure facility. Each facility has a director and staff responsible for overseeing and operating the day-to-day activities.

OCFS has the responsibility to ensure the safety of both youth and employees at its DJJOY facilities. This includes ensuring that: facilities are operated in good condition and in compliance with the DJJOY Policy and Procedure Manual (Manual); youth undergo the proper screenings and assessments upon admission; staff are properly trained; and when incidents occur, they are recorded and reviewed as necessary. The Manual requires facilities to undergo regular fire safety inspections, have an emergency plan in place, keep logs of certain events, provide safe drinking water, and maintain sanitary conditions.

Upon admission to a DJJOY facility, youth go through screening interviews and orientation with staff to discuss the youth's needs. Initial admission screening interviews are required within the first hour of the youth arriving at a facility, after which they are placed in a living unit based on their age, offense, legal and placement history, and assessed propensity to be victimized by or to victimize others. Staff are subsequently required to complete various assessments and screenings within the first week of the youth's admission to a DJJOY facility to assess their mental and physical health and familiarize the youth with the facility and its procedures. For example, youth who enter a DJJOY facility are required to receive a comprehensive medical assessment by a physician or mid-level practitioner within 7 days of admission. Also, orientation checklists are required to be completed within 3 days of admission.

When an incident occurs at a facility (e.g., assault, possession of contraband, self-harm, employee misconduct), staff at the facility must log and report the incident to OCFS. Incidents are reviewed by facility staff and OCFS, after which they are evaluated and resolved, or, if warranted, a review is initiated. Among the incidents that must be logged and reported are those involving restraint of a youth. These incidents are significant because they pose a potential danger of injury to both youth and staff.

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1 Silver, I.A., Semenza, D.C., & Nedelec, J.L. (2023). Incarceration of youths in an adult correctional facility and risk of premature death. *JAMA Network Open*, 6(7), e2321805. doi:10.1001/jamanetworkopen.2023.21805

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To be authorized to restrain youth at DJJOY facilities, direct care staff must, upon hire, complete a 40-hour crisis prevention and management (CPM) course that includes de-escalation skills and physical restraint techniques. Staff are also required to complete CPM refresher courses annually. To be authorized to restrain youth, staff must also annually take cardiopulmonary resuscitation (CPR) and first aid training.

The Manual requires a thorough review of restraint incidents when they occur. Staff are required to record and maintain additional information each time an incident occurs. Each incident must be recorded in the facility's restraint log, and a Restraint Monitoring form and an Administrative Review form must be completed. The Restraint Monitoring form is a tool used to evaluate the effectiveness of the interventions used during a restraint. The Administrative Review form captures detailed information on the restraint, including the staff involved, whether the staff were up to date on required CPM and CPR/first aid training, and any party notified that a restraint occurred (e.g., parent, guardian, law enforcement). After the Administrative Review form is completed, it is reviewed and approved by the facility director (or designee), who is responsible for verifying that all the necessary information is recorded and accurate. When staff complete all the required forms, they are filed as part of a restraint packet included in the youth's case record.

In addition to trainings related to restraining youth, the Manual requires DJJOY facilities to develop and maintain current emergency plans covering a variety of potential situations, which are part of a separate manual, the Ready Emergency Data (R.E.D.) Book. R.E.D. Book procedures are a mandatory component of training for all new employees, with an annual refresher course also required.

Between 2019 and 2022, DJJOY facilities faced a series of challenges, including the COVID-19 pandemic and new legislation that contributed to an increase in youth placement in DJJOY facilities as well as an increased number of incidents. Also, during this period, staffing fell and, consequently, overtime increased significantly.

According to national data from the U.S. Office of Juvenile Justice and Delinquency Prevention, the number of youth in State-operated facilities decreased by about 56% between 2013 and 2021, including a 33% decrease from 2019 to 2021 (the latest year national data was available). According to OCFS' Youth in Care Report, the population of youth in New York's DJJOY facilities fell from 409 in 2013 to 229 in 2018 – a decrease of 44%. However, beginning in 2018, the trend reversed, and the number of youth increased by nearly 74%, from 229 in 2018 to 398 in 2022 (see Table 1). It was during this period that New York's Raise the Age (RTA) legislation was phased in.

Enacted in April 2017, RTA 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 reoffense. Phased in over time, RTA 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 within the Criminal Court system, 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 13- to 15-year-olds 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. Therefore, these youth are placed by the court in DJJOY secure facilities. OCFS data shows that its DJJOY secure facilities – those where newly convicted adolescent offenders are placed – saw a decline in their youth population between 2013 and 2019 but then an increase of more than 200%, from 70 youth in 2019 to 216 in 2022. Generally, the increase was due to newly placed youth and not repeat offenders. Analysis of OCFS' admission data between October 2018 and April 2023 showed that just 4% of youth had more than one admission into a DJJOY facility. From 2019 to 2022, the number of youth placed in non-secure and limited-secure facilities decreased by approximately 44% and 2.3%, respectively (see Table 1).

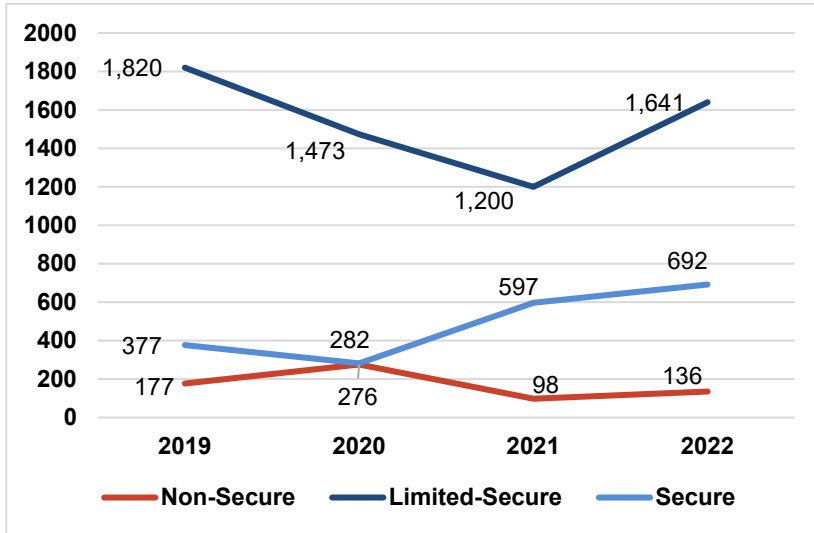
**Table 1 – Number of Youth in DJJOY Facilities and State-Operated Facilities Nationwide**

DJJOY Facilities	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Secure	187	173	165	129	107	77	70	86	125	216
Limited-secure	193	172	146	143	141	134	177	151	146	173
Non-secure	29	15	25	19	21	18	16	10	11	9
<b>DJJOY Total</b>	<b>409</b>	<b>360</b>	<b>336</b>	<b>291</b>	<b>269</b>	<b>229</b>	<b>263</b>	<b>247</b>	<b>282</b>	<b>398</b>
State-operated facilities nationwide*	13,970	–	12,308	–	10,772	–	9,123	–	6,087	–

\*Nationwide total youth in State-operated facilities data only available for the years provided.

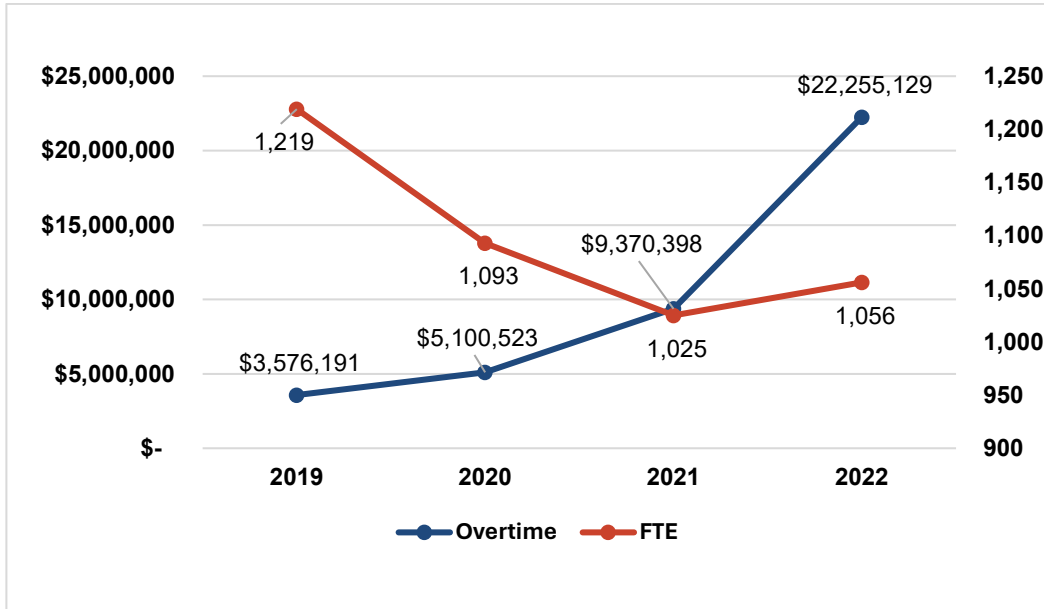
As the number of youth at secure facilities rose, so did the number of incidents. OCFS data shows a nearly 84% increase in incident reports at secure facilities, from 377 in 2019 to 692 in 2022 (note that a single incident report may include more than one type of incident). Generally, the increase in incidents leads to a more stressful environment for staff at the secure facilities. Incidents at DJJOY's limited-secure and non-secure facilities were, respectively, 9.8% and 23.2% lower in 2022 than they were in 2019 (see Figure 1).

**Figure 1 – Incidents by Facility Type 2019–2022**



While more youth were placed in secure facilities and incidents increased, DJJOY facilities – secure facilities in particular – experienced staffing shortages and large increases in overtime costs. According to OCFS’ data available through August 2023, staffing fell and remained below the approved fill levels across all DJJOY facilities beginning in 2021. According to the data, DJJOY facilities operated, on average, about 17% below their fill level between December 2021 and August 2023. The staffing issues were particularly acute at secure facilities, which were operating, on average, 38% below full staffing levels. Further, a review of full-time equivalent (FTE) staffing at the nine DJJOY facilities showed a decrease of about 13.4% between 2019 and 2022. Secure facilities showed a 9% decline in FTEs for this period while the population increased by over 200%. These staffing issues were further compounded by the challenges associated with operating during the COVID-19 pandemic. Collectively, these staffing challenges and the need to supervise more youth contributed to a 522% surge in overtime costs at DJJOY facilities, rising from about \$3.6 million in 2019 to \$22.3 million in 2022 (see Figure 2).

Figure 2 – Changes In DJJOY Facility Staffing and Overtime 2019–2022



# Audit Findings and Recommendations

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While we found DJJOY facilities are meeting State standards and regulations for the health and safety of youth and staff, and meet required physical conditions (e.g., sufficient lighting and ventilation, fire safety equipment), we found weaknesses in several aspects of OCFS' operation of DJJOY facilities. For example, we found OCFS has not ensured that certain admission assessments and screenings, including health-related assessments, were completed and documented as required or were done within the required time frames, creating a risk of missed or delayed opportunities to provide care for physical health or mental health issues youth may have when admitted to DJJOY facilities.

We also found OCFS did not ensure that direct care staff were current with training to be authorized to restrain youth and did not always ensure the reviews of those incidents were complete or thoroughly documented. As incidents involving restraint of youth present risks for both the youth and staff, it is critical that staff are adequately trained and each incident is thoroughly reviewed to reduce risk of harm to staff and youth and to reduce the likelihood that problems, conflicts, or behaviors will escalate to a level that requires physical intervention in the future.

OCFS officials attributed most of our findings to ongoing staffing challenges, and stated they recognize the effect of those challenges on providing critical assessments, keeping staff up to date on training, and other administrative functions. While officials stated they are attempting to recruit and retain staff, they cited pay rates for direct care staff and the stress and demand of the work, compounded by an increase in their youth population, as obstacles to achieving adequate staffing levels. However, we found OCFS could improve certain procedures and training techniques to reduce redundancies and help meet training requirements.

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

## Admission Assessments and Screenings

The admission process is essential for assisting youth in adjusting to and feeling safe in their new environment, and provides staff with an opportunity to learn more about the youth. Youth who enter juvenile justice facilities often have a history of physical health challenges and are far more likely to have mental health problems. Therefore, it is important to ensure they are receiving required physical and mental health assessments in a timely manner so they can obtain any necessary treatment and services. As such, several important assessments or screenings are required to be completed close to when youth are first admitted to a facility (generally within 7 days of arrival). When initial assessments and screenings – 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 health issues (e.g., depression, anxiety) youth may have when they are admitted. Additionally, if youth aren't receiving orientation as required, they may be delayed in or miss out entirely

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on connecting with services offered at the facility (e.g., educational and vocational services, reintegration programs).

Identifying and addressing issues with youth early in the admission process 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). According to the National Institute of Corrections, youth in custody have rates of substance use disorders ranging from 37% to 86%. Therefore, a significant number of youth require formal treatment for their use of alcohol or other drugs. One study<sup>2</sup> found that one in 10 incarcerated youth experienced depression, bipolar disorder, or schizophrenia and a substance use disorder; rates of substance use disorders co-occurring with conduct disorder and attention-deficit/hyperactivity disorder are likely even higher. Individuals with co-occurring disorders have also been shown to have higher rates of criminal behavior, relationship problems, depression, hospitalization, and poor compliance with medication regimens. Additionally, youth with co-occurring disorders are at increased risk of dying by suicide.

OCFS' incident data shows an increase in certain types of incidents between January 1, 2019 and December 31, 2022. For example, in secure facilities, there were no incidents relating to controlled substance contraband in 2019; however, in 2022, there were 37 incidents. Positive urine drug screenings were also up overall, by about 24% for the same period. Further, instances of self-harm at secure facilities were up 100% (from 24 to 48 incidents) – and those that included an expression or gesture of suicide were up 667% (from three to 23 incidents).

We reviewed admission files for 101 youth at six DJJOY residential facilities and found 53 files lacked support for completion of at least one of the required admission assessments or screenings – including those required to be done within the first week after admission. For example, we found missing documentation of: medical admission checklists (which document that all the required medical assessments were completed on time); history and systems review forms (used to document preliminary interviews with youth about their physical and mental health); orientation checklists (which track the completion of necessary orientation steps); diet order forms (used to note special dietary needs such as those associated with food allergies); and receipt of the New York State Bill of Rights for Children and Youth (detailing the rights of youth in DJJOY care) (see Table 2).

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<sup>2</sup> Teplin, L.A., Abram, K.M., McClelland, G.M., & Dulcan, M.K. (2003). Comorbid psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry*, 60, 1097–1108.

**Table 2 – Missing Admission Documentation**

Missing Support*	Total Youth Reviewed	Youth Missing Assessment or Screening Documents
Diet Order Form	101	31
Orientation Checklist	101	20
Medical Admission Checklist	101	11
NYS Bill of Rights for Children and Youth	101	4
History and Systems Review	101	6

\*Of the 53 files we found lacking support, some had multiple records missing.

We also found that 44 of 101 youth had at least one assessment or screening, such as the comprehensive medical assessment, completed late. For 36 of the 101 youth, the comprehensive medical assessment was not completed within 7 days of admission. For one youth, the assessment wasn't done for nearly 9 months (271 days), while for others it ranged from 4 to 78 days late. Other examples of late assessments or screenings included orientation checklists completed later than 3 days after admission and admission screening interviews that were not completed within the first hour of the youth's arrival at the facility (see Table 3).

**Table 3 – Late Admission Documentation**

Type of Assessment or Screening*	Total Youth Reviewed	Youth With Late Assessment or Screenings
Comprehensive Medical Assessment	101	36
Orientation Checklist	101	9
Admission Screening Interview	101	4

\*Of the 44 youth with late assessments or screenings, some had multiple that were late.

According to OCFS, staff turnover and shortages of direct care staff contributed to missing or delayed admission assessments and screenings, including health assessments.

## Staff Training and Restraint Incident Reviews

### Training Requirements

Training and education help increase the knowledge, skills, and competency of staff. Incidents involving restraint of youth are risky for both the youth and staff. Therefore, it is important that direct care staff remain current with training necessary for the authorization to restrain youth (CPR/first aid and CPM training). However, we found OCFS did not ensure that direct care staff were current with the training required to be authorized to restrain youth.

Between October 1, 2018 and April 30, 2023, there were 2,455 incidents involving a restraint. Of those, 1,789 (73%) resulted in an injury to youth or staff. We reviewed training records for 162 employees involved in 96 restraint incidents at six DJJOY

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residential facilities between April 5, 2020 and March 30, 2023. We found 87 (54%) employees were not up to date on either CPR/first aid and/or CPM training. Of the 87 employees, 27 were not current with CPR/first aid training, 21 were late with CPM training, and 39 were late in taking annual refresher training for both. In some cases, employees were significantly overdue for required training. For example, in one case, an employee was involved in a restraint incident in February 2023, but their CPR/first aid training had been expired since March 2020 – nearly 3 years before. In another instance, an employee involved in a different incident in February 2023 was overdue for CPM training by more than 2 years. For others, CPM training was overdue from 2 days to 2.27 years (827 days) and CPR/first aid training was overdue from 17 days to 2.24 years (816 days).

Training of direct care staff plays an important role in the safety of youth at DJJOY facilities. Should an emergency arise, it is critical that employees have been trained for, are familiar with, and understand how to perform during those situations. However, of 162 employees reviewed, 95 (59%) had not completed their annual R.E.D. Book (emergency procedures) refresher course, including one employee who last had the training in November 2018 (2.98 years [1,089 days] overdue) and others whose training was overdue by 24 days to 2.78 years (1,015 days).

CPM and CPR training are in-person, hands-on training. According to officials, these sessions were postponed during the COVID-19 pandemic. As a result, during this period, when employees were not up to date with the training requirements, OCFS officials waived the requirements, temporarily excusing employees from the training due to the pandemic and staffing circumstances. However, officials said these waivers were granted verbally, and, therefore, could not provide support to confirm whether the employees in our sample had received waivers for the training requirements or not.

According to OCFS officials, the effects of the pandemic continue to impact facility staffing. Although training schedules have returned to normal as of 2022, facility directors explained that ongoing staffing shortages have prevented employees from keeping current on training requirements. OCFS officials stated they are exploring the possibility of allowing staff to take non-physical, computer-based CPM and CPR training remotely. Additionally, they noted OCFS has adopted a new first aid training curriculum that certifies staff for 2 years, reducing the need for annual training.

## Review of Restraint Incidents

Physical intervention with youth should be minimized to the extent possible, and restraints should be used only to contain 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 to reduce the likelihood that problems, conflicts, or behaviors will escalate to a level that requires physical intervention in the future.

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We identified restraint incidents that were missing support that a complete review of the events had been conducted. In some cases, the incidents were not recorded in the restraint log or were missing Restraint Monitoring and Administrative Review forms. In others, the subsequent review and Administrative Review forms were not approved by the facility director (or designee).

We reviewed restraint packets for 106 incidents at six DJJOY facilities, occurring between December 10, 2019 and March 30, 2023, and found:

- 22 (21%) were not recorded in the restraint log.
- 9 (8%) were missing the Restraint Monitoring form.
- 6 (6%) were missing the Administrative Review form.
- 5 (5%) Administrative Review forms were missing evidence of approval from the facility director (or designee).

Although we identified 22 cases that were not recorded in the restraint log at facilities, OCFS officials noted that information on restraint incidents was recorded electronically in a separate database used to capture all aspects of restraint incidents for all nine facilities. The information recorded in the electronic database included the same information that should have been recorded in the restraint log at each facility. Officials stated they plan to review their procedures to determine whether the continued use of separate logs, in addition to the record maintained electronically, should still be required.

OCFS officials attributed the missing forms and approvals to staffing and turnover (compounded by the COVID-19 pandemic), which affected facilities' ability to fully conduct and document incident reviews.

## Recommendations

1. Review current administrative procedures and training curriculum and, where practicable, implement changes to enable staff to, at a minimum:
  - Complete admission assessments and screenings on time,
  - Meet training requirements, and
  - Complete restraint incident review and record-keeping requirements.
2. Determine the sufficient staffing levels necessary to adequately provide for the health and safety of juveniles and staff and increase efforts and focus resources to meet those levels.



# Audit Scope, Objective, and Methodology

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The objective of our audit was to determine whether OCFS adequately operates juvenile justice facilities for court-placed youth to ensure they meet State standards and regulations for the health and safety of juveniles and staff. The audit covered the period from October 2018 through August 2023.

To accomplish our objective and assess related internal controls, we reviewed State laws, regulations, and OCFS policies related to juvenile justice facilities; interviewed OCFS and DJJOY facility officials; observed DJJOY facility conditions; and examined OCFS and DJJOY 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 six (of nine) State-run DJJOY facilities, based on the type of facility and number of reported incidents, to observe the conditions at each facility and test compliance with selected portions of the Manual.
- A judgmental sample of 265 incidents (of 5,525), based on the facility where the incident occurred and the type of incident, to assess whether the incidents were reported accurately and followed reporting procedures in the Manual. We performed additional testing for 106 incidents (of 265) of physical restraint of youth to determine whether these incidents were reported accurately on facility restraint logs and had the appropriate documentation completed, reviewed, and filed according to Manual requirements. For 96 of the restraint incidents, we also assessed whether the 162 staff involved in those incidents were up to date on training required to perform physical restraints.
- A random sample of 101 youth (of 560), representing approximately 18% of the admissions at each of the six facilities, to test whether staff completed the required admission screenings and documents within the established time frames for those youth.

We obtained youth incident and intake data from OCFS' Juvenile Justice Information System. 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

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## 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 juvenile justice facilities.

## Reporting Requirements

We provided a draft copy of this report to OCFS officials for their review and formal written 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 recommendations and described actions that are already underway or are planned to address them. We address one aspect of their response in a State Comptroller's Comment.

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 recommendations contained herein, and where recommendations were not implemented, the reasons why.

# Agency Comments

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## Office of Children and Family Services

KATHY HOCHUL  
Governor

SUZANNE MILES-GUSTAVE, ESQ.  
Acting Commissioner

February 12, 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 2022-S-13 Response to the Draft Report

Dear Ms. 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) January 2024 Final Report S-13. OSC's stated objective of the audit was to determine whether OCFS adequately operates juvenile justice facilities for court-placed youth to ensure they meet state standards and regulations for the health and safety of juveniles and staff for the period from October 2018 through August 2023.

OCFS is grateful for the acknowledgement from OSC that OCFS Division of Juvenile Justice and Opportunities for Youth (DJJOY) facilities 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).

However, OCFS respectfully asserts that a large portion of this audit applied to a timeframe when the state and country dealt with the unprecedented and dramatic impact of the COVID-19 pandemic, as well as the collateral impact of a COVID-related state hiring freeze. Not unlike other human service agencies, this resulted in a severe staffing loss and negatively impacted staff recruitment and retention, a reality that continues today. Governor Hochul has recognized these staffing struggles by creating the NY HELPS initiative, where several OCFS juvenile justice facility positions are featured and have resulted in some new hires. Despite these workforce challenges, DJJOY facilities continue to maintain the health and safety of its youth and staff.

**OSC Key Finding #1:** OCFS has not ensured that certain admission assessments and screenings, including health-related assessments, were completed and documented as required, or were done within the required time frames, creating a risk of missed or delayed opportunities to identify or provide care for physical conditions or mental health concerns youth may have when they are admitted to DJJOY facilities.

**OCFS Response:** OCFS takes its responsibility of assessing youth upon admission seriously. As noted above, staffing was impacted by the pandemic during the relevant period. This included clinical staff responsible for the assessments. This shortage of clinical staff frequently required programs to implement a modified medical program with medical assessments conducted on living units, rather than at admission.

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It should be noted that OCFS completes assessments throughout a youth's time in placement, as mental and physical care needs can be fluid. Assessments do not end at admission and are only one part of a complete profile of a youth.

**OSC Key Recommendation #1:** Review current administrative procedures and training curriculum and, where practicable, implement changes to enable staff to complete admission assessments and screening on time.

**OCFS Response:** OCFS will work with facility staff who are responsible for admission assessments and screenings to ensure that all are timely and thoroughly completed in accordance with agency policy. Regional nurse supervisors will perform additional checks of all admission packets on a regular basis for accuracy. In addition, the following action steps have been implemented to better serve youth and to increase timely assessment completion:

- OCFS revised the *Medical and Dental Admission Checklist* and consolidated two versions to reduce redundancy, rendering OCFS-5361 unnecessary.
- OCFS categorized the tasks in form OCFS-5362, *Medical and Dental Admission Checklist* according to required time frames for completion. BHS will reissue this guidance and retrain facility nurse administrators regarding oversight.
- Facility nurse administrators will be required to review and sign off on all completed *Medical and Dental Admission Checklist* forms at the end of the time frame for completion.
- The Assistant Director of Nursing will review *Medical and Dental Admission Checklist* forms during each site visit.
- OCFS revised OCFS-5362, *Medical and Dental Admission Checklist* to include mandatory completion of OCFS-4672, *Diet Order Form* for all youth admissions.
- OCFS revised and updated OCFS-4672, *Diet Order Form*, and will educate appropriate medical staff that the form must be completed for all youth admissions and submitted to kitchen staff.

In addition to these action steps, OCFS will review its policies to ensure there are no inconsistent expectations regarding admission screenings and assessments.

**OSC Key Finding #2:** OCFS DJJOY did not ensure that all direct care staff were current with training to be authorized to restrain youth.

**OCFS Response:** The noted facility staff shortages impacted the ability for facilities to release staff from their ordinary responsibilities to receive training, including Crisis Prevention Management (CPM) restraint training and First Aid training. During the height of the COVID-19 pandemic, OCFS focused on ensuring that new staff received all necessary trainings to be able to properly fulfill their roles, rather than providing refresher trainings to seasoned staff without performance issues.

OCFS tracked training lapses and implemented training waivers when appropriate. OCFS cross-reviewed staff waivers against any Justice Center determinations to identify staff who most required training and to ensure staff issued a training waiver had no outstanding investigations relating to improper restraint technique or usage. Additionally, training was negatively impacted because training for restraints is typically conducted in-person with elements of close physical contact, thereby limiting the availability of these trainings due to pandemic distancing requirements.

Even though staffing remains in a critical state, OCFS has been focused on ensuring that all staff are brought current with their training requirements.

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**OSC Key Recommendation #2:** Review current administrative procedures and training curriculum and, where practicable, implement changes to enable staff to meet training requirements.

**OCFS Response:** OCFS continues to review DJJOY training requirements and delivery to identify inefficiencies. OCFS also adopted a new first aid training curriculum that certifies staff for a 2-year period, versus the previous training that certified staff for a 1-year period. OCFS is exploring alternate methods of training that will allow staff to complete required trainings remotely to minimize the impact of staff unavailability at their assigned program site.

**OSC Key Finding #3:** OCFS did not always ensure the investigations of incidents were complete or thoroughly documented.

**OCFS Response:** OCFS does not investigate incidents in its own facilities; allegations of staff misconduct are handled by the Justice Center for the Protection of People with Special Needs. However, OCFS randomly reviews a broad sampling of restraint incidents, including review of all available video and restraint documentation, to identify any deficiencies in practice and follows up with individual facilities where review indicates the need for additional support or training.

[Comment 1](#)

**OSC Key Recommendation #3:** Review current administrative procedures and training curriculum and, where practicable, implement changes to enable staff to complete restraint incident review and record-keeping requirements.

**OCFS Response:** OCFS continues to work with facility leadership to ensure that staff tasked with completing administrative review of physical restraints are properly trained, any deficiencies corrected, and expectations reconveyed.

With respect to OSC's finding that not all restraints were appropriately logged, the restraint log, while an important facility tool, is one of two places where restraints are documented. As acknowledged by OSC, staff document each restraint within the Automated Restraint Tracking System (ARTS). This electronic system captures all aspects of the physical, bound logbook. OCFS will review the need to continue to use both the physical logbook and ARTS with an eye toward reducing redundancy and increasing data consistency.

In addition, OCFS conducts site reviews at each facility twice annually, to review compliance with incident reviews and record-keeping requirements. Any significant departure from policy demands is subject to corrective action.

**OSC Key Recommendation #4:** Determine the sufficient staffing levels necessary to adequately provide for the health and safety of juveniles and staff and increase efforts and focus resources to meet those levels.

**OCFS Response:** OCFS has long-established safe staffing levels to adequately provide for the health and safety of youth and staff within our facilities. OCFS has implemented extensive recruitment efforts at all DJJOY facilities, including use of job boards, job fairs, changing civil service pay grades, and paying onboarding and retention bonuses to better attract and retain staff. OCFS is exploring options to better train and prepare staff for the rigors of facility work with the goal of increased staff retention and supporting the best outcomes for youth.

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**Conclusion:**

OCFS will review OSC's findings and recommendations with facility administrative teams as part of its continuous quality improvement efforts to better provide services to youth and support facility staff. With that, OCFS anticipates 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 serving the youth in its custody. Please contact myself or Deputy Commissioner Reid with any questions regarding this response.

Sincerely,



Suzanne Miles-Gustave, Esq., Acting Commissioner  
Office of Children and Family Services

cc: Felicia A. B. Reid, Esq. Deputy Commissioner, Division of Juvenile Justice and  
Opportunities for Youth  
Jill Swingruber-Sprotberry, Esq., General Counsel  
Bonnie Hahn, Acting Director, Office of Audit and Quality Control

# State Comptroller's Comment

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1. Our audit work focused on the administrative reviews and associated documentation required as part of those reviews under the OCFS Crisis Prevention and Management Policy. We have further clarified this in the final report.

# Contributors to Report

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