Memorandum

CRIPA Investigation

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DJ 168-32-63; DJ 168-33-108

Subject	Date
Louisiana Juvenile Training Facilities Findings Letter	June 13, 1997

To

Isabelle Katz Pinzler
Acting Assistant Attorney General
Civil Rights Division

From

Steven H. Rosenbaum
Chief
Special Litigation Section

Attached for your approval is a proposed findings letter advising the Governor of Louisiana of the findings of our investigation of the four secure correctional facilities for juveniles in Louisiana -- Louisiana Training Institute at Bridge City, Jetson Correctional Center for Youth, Swanson Correctional Center for Youth, and Tallulah Correctional Center for Youth -- pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997 et seq. and the pattern or practice provision of the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141.[1] The State provides secure care for approximately 1,700 juveniles adjudicated delinquent in these facilities. Fewer than 25 percent of these juveniles committed violent crimes.

During the past year, we conducted an exhaustive investigation of these facilities. We began the investigation with tours of the four facilities during the summer of 1996 with experts in the fields of abuse investigations, juvenile justice, education, and psychiatric care. We toured the facilities again in December 1996 and January 1997 to evaluate the State's representations that they had corrected some of the violations. In addition, we have interviewed key State officials, institutional staff, and hundreds of juveniles and have reviewed thousands of documents, including juveniles' records, incident reports and abuse investigations. On the basis of our investigation, we have identified a number of conditions that continue to violate the federal rights of juveniles under the First, Eighth and Fourteenth Amendments of the Constitution as well as several federal statutes.

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[1] We initiated this investigation at the request of former President Jimmy Carter, who brought conditions at these facilities to Attorney General Reno's attention following a Human Rights Watch Report detailing widespread deficiencies.

The attached findings letter would follow two interim emergency letters that we sent to the Governor of Louisiana regarding life-threatening problems we uncovered during our investigation. In the interim letters, dated July 15, 1996 and October 3, 1996, we informed the Governor of systemic problems with staff abuse and juvenile-on-juvenile violence. In the October 1996 letter, we also delineated dangerous medical and mental health care deficiencies. We include these letters as attachments to the findings letter. Although Louisiana took some steps to address these deficiencies, the measures that they took were insufficient to correct the problems and afford juveniles their constitutional and federal statutory rights.

This findings letter is similar to and consistent with the deficiencies and remedies we identified in our findings letter involving all 13 juvenile treatment facilities in Kentucky. The conditions at the secure juvenile facilities in Louisiana that violate the constitutional and federal statutory rights of residents include:

1. Failure to protect juveniles from harm.

In spite of alerting the State twice to the violent conditions at the facilities and providing the opportunity to correct these conditions voluntarily, we uncovered continuing serious, systemic, and, in certain cases, life-threatening, violence during our re-tours. Correctional staff continue to physically and sexually abuse juveniles. Guards continue to use mace inappropriately, sometimes using it on juveniles in restraints. Restraints continue to be used inappropriately. Juvenile-on-juvenile violence continues to pervade the system. With the exception of the Jetson facility, abuse investigations continue to be inadequate. The State continues to fail to classify juveniles adequately within the facilities, creating an unsafe environment for vulnerable juveniles. The State's own task force concluded in its December 1996 report that small and young children, who are especially vulnerable and at risk, are being harmed in these facilities. Dozens of juveniles continue to suffer serious injuries such as fractures to jaws, noses, cheeks, and eye sockets and lacerations requiring sutures on a monthly basis.

2. Inadequate medical and mental health care.

The State provides inadequate medical and mental health care to a substantial number of confined juveniles. The facilities fail to screen and assess juveniles' medical conditions adequately, and their quality assurance procedures fail to identify their errors. Access to care is impeded by correctional staff in three of the facilities. Dental care, which is generally limited to extractions, is systemically inadequate.

Each facility suffers other serious discrete problems in medical care delivery.

With respect to mental health care, the facilities lack psychiatric staffing to ensure adequate care for juveniles. Tallulah, for example, has no psychiatrist; juveniles who have mutilated themselves and/or have threatened suicide have never been referred to a psychiatrist. The facilities are replete with suicide hazards, especially in Bridge City where the State specifically places depressed and suicidal youth. Mental health assessments, counseling, and treatment deviate from professional standards. Staff are not adequately trained to meet the needs of juveniles with mental retardation or mental illness. Moreover, the State confines mentally ill or mentally retarded juveniles in secure facilities, in spite of placement recommendations for nonsecure treatment.

3. Inadequate education and rehabilitative services.

At all four facilities, general and special educational services, including related services, are deficient, violate constitutional due process and equal protection, or fail to meet the legal mandates of the IDEA. Our consultants concluded that the education programs in the facilities "operate completely outside the bounds of acceptable educational practice." Most of the juveniles do not receive the State-mandated minimum of 5-1/2 hours of schooling per day, and some youth, who are eligible for schooling, are not enrolled in school at all. Little or no instruction occurs in many of the classes. The facilities deny many juveniles educational services while they are housed in isolation. Vocational training is nonexistent in two facilities and is inadequate in the other two.

All four facilities fail to provide juveniles with adequate rehabilitation. Instead, during many non-school hours, officers force juveniles to sit in silence without shifting their positions, and punish or hit the juveniles if they fail to do so. Our experts concluded that "students are unable to maintain their academic progress, fail to develop new skills, and are no more prepared to re-enter their home communities than when they were initially confined." As we found in Kentucky, Louisiana fails to provide appropriate case management/aftercare to juveniles upon release from the facilities. While the law in this area is not well developed, our expert believes that aftercare is a necessary component of successful rehabilitative care.

4. Other juvenile justice deficiencies.

Overly-restrictive facility practices with respect to mail, telephone, and visitation deny juveniles their freedom of association and communication. The facilities also fail to

provide juveniles with adequate access to courts during their confinement.[2]

The findings letter sets forth the necessary remedial measures to correct the violations found and informs State officials that we look forward to negotiating with them to resolve the existing systemic deficiencies.

During the course of our investigation, we also found that many juveniles work instead of receiving a full day of school instruction. Without pay, juveniles are required to perform such tasks as blacktopping parking lots, cleaning swimming pools, replacing roofs, and working on road crews picking up litter. We have discussed this issue with the Associate Solicitor of the Fair Labor Standards Division at the Department of Labor and he is willing to evaluate these practices to determine if they violate the Fair Labor Standards Act. Accordingly, we propose to refer this matter to the Department of Labor for review.

Because conditions at the four facilities are before the court in Williams v. McKeithen, CA 71-98-B (M.D. La), we propose sending a copy of the findings letter to the court and counsel in that case and so advise the State in our findings letter. As discussed in our original recommendation to investigate, juveniles at each of the facilities are part of the Williams class. Williams is a class action filed in 1971 originally concerning only conditions at the Louisiana State Penitentiary at Angola. Although the United States participated as intervener on the race issues and as *amicus* on all other issues in the original litigation, we have not participated in the case since the early 1980's.[3] In 1984, the court expanded Williams to include the State's secure correctional facilities for juveniles and ordered the State to enter into limited "consent decrees" governing each of these facilities.[4] In 1994, the court declared a state of emergency at Tallulah, and the Williams court-appointed monitor continues to monitor closely conditions at that facility.

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[2] We are continuing to investigate whether the State's system for providing juveniles with adequate legal representation during the adjudication process violates the Constitution and creates a cause of action under 42 U.S.C. § 14141.

[3] There is a separate case, also called Williams, filed in 1992, concerning only medical care at Angola. Although the judge permitted the United States to intervene in this case, he did not permit us to participate in the trial in 1994. There is not yet a decision on the merits in this case.

[4] Neither the United States nor plaintiffs are signatories to these "consent decrees."

The United States Attorneys for the Western, Middle, and Eastern Districts of Louisiana have been advised of the findings of our investigation.

If you approve, your signature is required on the attached letter.

Attachment

Approved _____

Disapproved _____

Comments:

U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General

Washington, D.C. 20035

The Honorable Mike Foster
Governor of Louisiana
State Capitol
P.O. Box 94004
Baton Rouge, LA 70804-9004

June 18, 1997

Re: Findings of Investigation of Secure Correctional Facilities for Juveniles in Louisiana

Dear Governor Foster:

I am writing to report our findings with respect to our investigation of the four secure correctional facilities for juveniles in Louisiana -- Louisiana Training Institute - Bridge City ("Bridge City"), Jetson Correctional Center for Youth ("Jetson"), Swanson Correctional Center for Youth ("Swanson") (formerly known as Louisiana Training Institute - Monroe), and Tallulah Correctional Center for Youth ("Tallulah"). We first notified you on April 25, 1996, that we were initiating an investigation of these facilities pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997 *et seq*. CRIPA authorizes the Attorney General to investigate conditions at juvenile correctional institutions that are owned by a State or operated on behalf of a State. 42 U.S.C. § 1997(1)(B). On July 15 and October 3, 1996, we notified you that conditions at these four facilities were also covered by our authority to enforce the pattern or practice provision of the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141.

We conducted our investigation beginning with tours of the four facilities during the summer of 1996 with five expert consultants in the fields of juvenile justice, education, medical and mental health, and abuse prevention, and re-toured each facility during the winter of 1996-97. Our tours took place on the following dates: Bridge City on June 3-4, 1996, July 29-31, 1996, and December 16, 1996; Jetson on June 5-7, 1996, July 24-26, 1996, and December 17-18, 1996; Swanson on August 19-21, 1996, August 26-28, 1996, and January 21-22, 1997; and Tallulah on August 21-23, 1996, August 28-30, 1996, and January 23-24, 1997. During our tours, we interviewed several hundred juveniles confined at the facilities, as well as staff and administrators. In addition, we reviewed numerous facility and State documents and individual juveniles' records before,

during, and after the tours. Our experts provided facility and State officials with feedback during their tours, and we had several meetings and phone conferences with these officials to discuss a number of issues that arose during the course of our investigation. We wish to thank Louisiana officials, personnel, and counsel for providing their full assistance and cooperation throughout our investigation.

At each of the four facilities, we uncovered systemic life-threatening staff abuse and juvenile-on-juvenile violence. The gravity of the situation necessitated our sending two interim emergency letters to you -- the first on July 15, 1996 (Attachment A) and the second on October 3, 1996 (Attachment B). Our October 3, 1996, letter also informed you that certain medical and mental health problems at Swanson and Tallulah posed serious risks of harm to the juveniles confined there. In both emergency letters, we notified you that the results of our investigation provide the United States with a basis for action pursuant to CRIPA and 42 U.S.C. § 14141.

The State responded immediately to the concerns expressed in our letters to you. On August 1, 1996, the Secretary for the Department of Public Safety and Corrections announced his initiative to eliminate violence from Louisiana's secure correctional facilities for juveniles, calling the initiative Project Zero Tolerance. The Secretary's strong commitment to the goals of the Project are evident, and a number of the efforts made since the Project was initiated are significant. As we will explain in more detail below, however, there is still much to be done to achieve and maintain the goal of Project Zero Tolerance in the facilities.

Although the State implemented many of the measures suggested in our emergency letters to you with its Project Zero Tolerance initiative, it either refused or failed to implement several other suggested emergency measures. Furthermore, a number of the Secretary's proposed initiatives have been delayed due to lack of funding or other resources. For instance, last October, the State agreed to install additional surveillance cameras at Tallulah. These cameras are not yet in place. Exit interviews conducted by the Project Zero Tolerance Task Force confirm that youth regard camera surveillance as an important component in efforts to stem the tide of excessive use of force in the facilities.

Consistent with the statutory requirements of CRIPA, we write to advise you of the findings of our investigation. Many conditions in Louisiana's four secure correctional facilities for juveniles violate the constitutional and statutory rights of the juveniles confined therein. Conditions in the Louisiana secure correctional facilities for juveniles violate the First, Eighth, and Fourteenth Amendments to the Constitution of the United

States. See, e.g., United States v. Virginia, 116 S. Ct. 2264 (1996); Youngberg v. Romeo, 457 U.S. 307 (1982); Bounds v. Smith, 430 U.S. 817 (1977); Estelle v. Gamble, 429 U.S. 97 (1976); Turner v. Safely, 482 U.S. 78 (1987); Jackson v. Indiana, 406 U.S. 715 (1972); In re Gault, 387 U.S. 1 (1967). Conditions also violate the Americans with Disabilities Act of 1990, 42 U.S.C. § 12132 and its implementing regulations; the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. § 1400 et seq.; and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794. In addition, a pattern or practice of conduct that deprives juveniles of rights, privileges, or immunities protected by the Constitution or laws of the United States exists in Louisiana secure correctional facilities for juveniles in violation of the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141.

I. FINDINGS

The State provides secure care for approximately 1700 juveniles adjudicated delinquent in three state-owned and operated correctional facilities, Jetson, Swanson, and Bridge City, and in one privately-owned and operated facility, Tallulah. Jetson provides care for 470 males and 150 females. Bridge City provides care for 180 males, most of whom have been identified as young and vulnerable. Swanson provides care for 396 males. Tallulah, which provides care for 536 males, operates both a boot camp and the system's most secure settings on a closed campus. Juveniles confined to these facilities range in age from 10 to 20; 85 percent of the youth are under age 18. About 70 percent of the 1700 juveniles are at or below an 8th grade education level; about one-third of the 1700 juveniles have been identified as needing special education. Eighty-three percent of the juveniles are African American. In 1996, fewer than a quarter of the youth confined in these facilities committed violent crimes.

A. Failure to Protect Juveniles from Harm

Our investigation uncovered serious, systemic, and, in certain cases, life-threatening, harm being inflicted on the juveniles in all four facilities. We cited numerous examples in our prior correspondence. Serious physical injuries to youth from officer assault or from attacks by other youth have occurred at all four facilities. Literally dozens of juveniles are being seriously injured on a monthly basis across the four facilities. Especially at Tallulah and Swanson, the incidence of fractures to jaws, noses, cheeks, and eye sockets, as well as serious lacerations requiring sutures (usually also to faces) is disturbing. At all four training institutes, correctional staff abuse the juveniles. The abuse ranges from officers physically hitting, punching or kicking youth (sometimes when they are handcuffed), to officers negotiating "contracts" with juveniles

to beat up other juveniles to officers compelling juveniles to sit, stand, or lay in positions that are clearly painful and constitute corporal punishment. We also found evidence of sexual abuse and assault at each of the four facilities. The violence at the facilities is so pervasive that our consultant concluded that "the greatest responsibility for the problems seen must be directed to the institutes' administrators and senior staff. It is clear that these men and women either knew or intentionally sought not to know of the serious violence to children that was occurring [at the facilities]."

Unfortunately, despite the initiatives the State has taken in recent months to stem the violence we discovered during our initial tours during the summer of 1996, re-tours confirm that an unacceptable level of violence remains at all of the facilities, especially at Tallulah and Swanson. In addition, at all facilities, little attention has been paid to sexual activity between juveniles and between officers and juveniles.

This is not to say that the Secretary's Project Zero Tolerance initiative has had no effect. With the possible exception of Tallulah, interviews with children and staff at all facilities indicate a strong awareness of Project Zero Tolerance and changes in the institutions' culture where only a few months earlier the rule of violence had been so accepted. The singular progress at Jetson bears special mention. At Jetson, the superintendent has undertaken many initiatives beyond those specified in Project Zero Tolerance and is a strong personal voice in reinforcing the mission of the Project. The Jetson superintendent also has recruited a strong management team over both security and program services that daily reinforces the goals of Project Zero Tolerance. Officers and program staff at Jetson report that the "code of silence" among officers is breaking down, resulting in officers coming forward to report misdeeds and abusive conduct of their colleagues.

1. Abuse

At each facility, there are correctional staff who have not embraced the goals of Project Zero Tolerance. Indeed, it is disturbing that in spite of the clear message that no undue use of force would be tolerated with the initiation of Project Zero Tolerance, some staff have continued to physically assault the juveniles in their care. For instance, <u>since the inception of Project Zero Tolerance</u>, the following examples of staff abuse have occurred:

- a lieutenant at Bridge City punched a child in the eye and threw him through a screen door, while a teacher watched;

- videotapes at Swanson have recorded separate incidents of a guard karate kicking a juvenile in the head and a guard punching a juvenile;

- at Jetson, juveniles alleged that guards beat them with broken brooms hidden in the attic above their dorm, and when facility investigators found the brooms, the guards refused to be fingerprinted;

- at Jetson, a guard repeatedly whipped two females with a belt - one girl was whipped allegedly because it was her birthday and the guard had a practice of whipping juveniles on their birthdays, and the other girl was whipped allegedly because she was going to be discharged shortly;

- at Tallulah, a captain discovered guards beating up juveniles, including one child whose hands were cuffed behind his back who was bleeding heavily from the mouth, and guards macing youth while they were being held by other guards; and

- at Tallulah, a guard told a juvenile that he wanted to "drive his dick" in the juvenile's mother's mouth during visitation, leading to a verbal argument that resulted in the guard repeatedly punching the child in the jaw with both his left and right fists, even after the child fell to the floor and attempted to block the guard's blows, and the guard throwing and hitting the child in the head with a radio.

Regrettably, months after the implementation of Project Zero Tolerance, records and interviews confirm that staff routinely continue to kick, hit, slap, stomp, choke, scratch, and slap juveniles in these facilities. In fact, in its December 1996 Report, the Project Zero Tolerance Task Force concluded that "[t]he use of force in the institutions is still a big problem."

The abusive use of mace at all facilities except Bridge City also violates juveniles' constitutional rights. Many juveniles at Swanson and Tallulah reported that guards sometimes mace juveniles in restraints, which clearly constitutes use of excessive force. At all facilities except Bridge City, juveniles also continue to be sprayed inappropriately with mace in situations where there is no present danger to the juvenile or to others. For example, juveniles recently have been sprayed with mace for refusing to shave, refusing to stop talking, refusing to sit down, refusing to leave a quiet time room, kicking their door, and, on the morning of our most recent tour of Tallulah, not arising from bed promptly enough. In none of these incidents did the juvenile engage in dangerous behavior prior to being sprayed. Rather, staff routinely use mace instead of less

intrusive, more appropriate measures of control and de-escalation. Furthermore, in many situations, mace continues to be used as a disciplinary measure long after a threat of danger has passed. At Tallulah, both staff and juveniles told our consultant that the use of mace is under-reported. Similarly, the Project Zero Tolerance Task Force noted in its December 1996 Report that although there were no official reports of use of mace at Tallulah during December, youth at Tallulah reported that officers had maced them during that month.

The final type of abuse found at all four facilities involves the use of corporal and other forms of unofficial discipline against juveniles. Staff who are poorly trained and supervised have resorted to unapproved methods of disciplining youth that have become institutionalized. Examples include: unit "initiations" (whipping and beating juveniles) and forcing offenders into "the cut" (out of camera range) to fight other youth or be punished physically by guards.

The extent of abuse at the facilities appears to be understated due to systemic deficiencies in reporting. Sometimes guards refuse to take abuse victims to the infirmary to seek medical attention. When juveniles are brought to the infirmary, oftentimes, fearing retaliation, the juveniles camouflage the real cause of their injuries, reporting them as accidents instead of staff abuse. The Project Zero Tolerance Task Force concluded in its December 1996 Report that "very few youth had confidence in the [abuse] reporting system," and our consultant found that just filing an allegation of abuse could get a child into trouble with the staff assigned to care for him or her. Infirmary logs at all facilities indicate that juveniles continue to suffer suspicious injuries that require more follow-up or investigation than the facility provided. Documentation also suggests that medical personnel readily accept accounts of injuries that appear spurious and they often do not make substantial efforts to encourage youth to be more forthcoming about the true cause of the injury. Medical personnel at some of the facilities also continue to interview juveniles about the cause of their injuries in the presence of security personnel from the juvenile's dormitory who escorted the juvenile to the infirmary. Finally, staff's legal and professional obligation to report suspected abuse has not been reinforced in training or in daily supervisory practices. The Project Zero Tolerance Task Force concluded in its December 1996 Report that "[t]he training needs for correctional, treatment and medical staff at the juvenile institutions is overwhelming. It will take a long time to get the staff trained in the manner that is needed to address the issues that have become evident through the PZT [Project Zero Tolerance] Project." In short, in a system where all but a few youth expressed a fear of retaliation, it is evident that

Louisiana is failing to provide injured children with a meaningful and appropriate opportunity to report all instances of abuse.

Staff at each of the four facilities are inadequately trained to intervene in crisis situations involving juveniles, which is a contributing factor to the ongoing constitutional violations. In many cases, staff are left to their own devices to control the juveniles. This, of course, creates a dangerous environment for all involved. A review of use of force incidents occurring both before and after the Project Zero Tolerance initiative confirmed staff's lack of training and knowledge regarding techniques other than brutal force for intervening effectively in crisis situations involving youth. These reports revealed that it was common and expected that officers would break up fights between juveniles by joining in the fight and "winning." Officers in the facilities have received police-type training inappropriate for working with confined youth.

2. Unreasonable Restraints

Restraints are inappropriately used at the facilities. For instance, when we toured Jetson during the summer of 1996, institutional policy permitted juveniles to be "hog-tied;" that is, youths were forced to sit for several hours cuffed at both the ankles and wrists, with the wrist cuffs attached to the ankle cuffs under the thighs, as a punishment for behavior. We found several incidents of this type of restraint being used on youth. One girl was even hog-tied as a suicide precaution. To his credit, the Secretary banned this practice on the spot when we told him about it. However, handcuffs continue to be used in the facilities long after youths are calm and pose no clear and present danger to anyone.

All facilities except Bridge City use segregated isolation as punishment. Despite the Secretary's November 1996 announcement that segregated isolation may be used only when a youth presents a danger, at all facilities except Bridge City, segregated isolation continues to be used frequently, often in non-dangerous situations, often not as a last resort, and often as a punitive measure. Tallulah administrative staff did not deny that segregated isolation continues to be used as punishment. At Swanson, isolation continues to be used for relatively minor offenses and as punishment for a large percentage of the resident youth. At Jetson, many offenders continue to be confined arbitrarily to 24-hour disciplinary isolation while awaiting their hearing. These practices deviate from accepted standards of care and are in direct violation of the Secretary's newly-promulgated policy. In addition, at Tallulah, youth with suicidal tendencies and youth engaging in self-mutilation are disciplined with segregated isolation for

their mental health problems. This response to such dangerous behaviors is contrary to accepted medical standards.

3. Juvenile-on-Juvenile Violence

In addition to the continuing excessive use of force by guards, Louisiana continues to fail to protect juveniles adequately from harm in several other critical respects. Infirmary logs at all four facilities still document daily fights among juveniles, some of which result in severe injuries. Furthermore, because these altercations are often halted with use of force by the officers, juveniles continue to get hurt in situations where less restrictive interventions than physical force would have been appropriate. At Swanson, in addition to frequent juvenile-on-juvenile fights, there was also a marked increase in gang fights involving as many as 15-20 juveniles. At Tallulah, during a recent two month period, 40 youth were transported to the local hospital for incidents involving acute trauma, primarily due to fighting.

4. Inadequate Abuse Investigations

In order to facilitate the reporting of abuse by staff and other juveniles at the facilities, the Secretary instituted a toll free hotline to the Project Zero Tolerance Task Force Special Investigator in Baton Rouge. During our investigation, however, we found that juveniles did not have reasonable access to the hotline. At Tallulah, access to the hotline was inadequate because youth could not use the phone anonymously. Youth requesting to use the hotline were cuffed and shackled and escorted to the phone located in the infirmary by security. A log was kept of the youth who used the phone. Given the pervasive fear of retaliation expressed by all but a few interviewed youth, this system discourages use of the hotline at Tallulah. In addition, Tallulah failed adequately to educate juveniles regarding opportunities for hotline access. For the other three facilities, youth did not have direct access to the hotline, although the Secretary recently anncunced that all juveniles would have access to the hotline on dormitory phones. Nonetheless, the Project Zero Tolerance Task Force concluded in its December 1996 Report that the hotline is "not working for the majority of incarcerated youth who do not have advocative parental relationships, who are weak, developmentally disabled or fearful of retaliation."

With the exception of Jetson, where recent internal investigations now meet accepted professional standards for child abuse investigations, facility abuse investigations continue to depart substantially from accepted professional standards. At Bridge City, Swanson, and Tallulah, abuse allegations are rarely sustained, even where the victim's allegations are very specific, document injuries that are consistent with the allegations, and

several other juveniles witness the abuse. Until very recently, photographs were not usually taken of injuries. Physical evidence alleged to have been used as weapons (for instance, chairs, keys, handcuffs, etc.) are almost never safeguarded after violent incidents. Victim's statements are often not taken in private. Initial statements of officers, victims, and witnesses are not taken by the special investigator, but by supervisory correctional staff, thereby defeating the independence and objectivity of the investigation. Investigators regularly discount the testimony of a juvenile without any reasoned review of its credibility, even when there are similar, credible, and specific accounts from multiple youth. There is some evidence, however, in recent investigations conducted at Swanson that investigators are beginning to factor the testimony of juveniles into their findings.

Many very serious injuries to juveniles are not investigated at all. Injuries that youth attribute to accidents or assaults by other youth usually are not investigated. This is particularly troubling in light of the number of juveniles who allege that guards avoid the consequences of staff abuse by negotiating contracts with juveniles to act as "hit men" for the guards and assault their peers for payments such as extra snacks or cigarettes. The practice of disciplining juveniles for filing abuse allegations that are not sustained further contributes to the juveniles' wariness to come forward with allegations.

In stark contrast to internal investigations that continue uniformly to evidence serious problems, the quality of the investigations conducted by supervisory investigator Major McDonald were complete and thorough and reflected a thoughtful and critical review of the evidence. Major McDonald recently resigned to accept employment in the private sector. Major McDonald's successors, Major Ted Price and other members of the Project Zero Tolerance special investigations team, should continue to develop and implement the special investigatory process, which will assist in reducing the violence at the juvenile facilities in Louisiana.

Although the Secretary has ensured, through Project Zero Tolerance, that each facility has a special investigator, these designated individuals had received very little training as of our January 1997 tours. Major McDonald's supervision of individual facility investigators has resulted, except at Tallulah, in investigations that are slowly becoming more thorough, and instances where officers make false or misleading statements are beginning to be addressed. In addition to insufficient training, facility investigators continue to be supervised by facility administrators rather than by the Secretary or his designee. This arrangement does not adequately ensure that facility investigators can perform their duties independently and be assured full cooperation by facility staff.

In addition, there are not enough investigators in light of the large number of abuse allegations made. Most of the facility investigators are expected to perform other duties. These additional assignments not only rob investigators of time needed to devote to investigations, but also, in some cases, may present direct conflicts of interest with their roles as special investigators. Moreover, the State has not established a policy setting forth reasonable time frames to conduct investigations in a timely fashion. For example, the investigators are made to work under unreasonably truncated time frames at Bridge City, Jetson and Swanson, forcing investigators frequently to forego a thorough investigation for the sake of a timely one. By contrast, at Tallulah, where there are no time frames for conducting an investigation, the investigator has an extraordinarily large open caseload, many of which have been open for longer than 60 days. Guidelines setting reasonable time frames would help ensure that investigations are completed in an expeditious and thorough manner.

5. Inadequate Classification

Another contributing factor to the unsafe environment in Louisiana's juvenile facilities is that all four facilities fail to meet current accepted standards relating to classification to protect juveniles from harm. For instance, at Bridge City, which is supposed to provide protective custody for the system's most vulnerable children, older, stronger juveniles are often housed with younger, smaller boys. This practice has led to unsafe conditions for the system's most vulnerable children. Almost all of the younger children at Bridge City voiced fears about their safety not only to us but to counselors and medical staff. We heard repeated accounts of physical and sexual assault by other children. At Swanson, some juveniles, through no fault of their own, are forced to live in restrictive conditions with aggressive peers in order that the facility fill all of its beds. Finally, youth with mental health problems that result in disruptive and/or self-destructive behaviors are transferred routinely to Swanson's and Tallulah's restrictive units where they experience prolonged periods of isolation and deprivation of a number of services without needed treatment for their underlying mental health problems. For many of these youth, such a transfer is counterproductive to treatment needs. Many of these youth increased their self-mutilation and disruptive behaviors as a result of increased isolation.

6. Inappropriate Commitments to the Facilities

Louisiana is failing to protect a substantial number of the children confined in its secure facilities from harm by placing them in these facilities in the first place. The State's own post-adjudication screenings identified a number of juveniles, many of whom have special needs, including mental or physical

disabilities, who were appropriate for nonsecure placements upon commitment to the Department. However, these recommendations were overridden, resulting in these youth being placed in secure facilities. State officials have advised us that these recommendations were not implemented because there are an insufficient number of appropriate alternative placements for these juveniles. Indeed, the Project Zero Tolerance Task Force concluded in its December 1996 Report that "[t]he [secure juvenile] institutions are filled with discarded children and youth from the mental health, developmental disabilities, educational, public health and child welfare systems of care."

In addition, the Task Force also concluded that small and young children, who are especially vulnerable and at risk, have been inappropriately placed in Louisiana's secure facilities and are being harmed during their confinement. For instance, the Task Force cited the case of a small, hyperactive youth at Bridge City who was severely beaten by an officer at Bridge City in December 1996, concluding that the youth is "completely inappropriate for commitment to the Department." Our consultants agreed that many juveniles confined in Louisiana's secure juvenile facilities have been placed inappropriately in the facilities and are at risk when they are co-mingled with more dangerous youth.

B. Inadequate Medical and Mental Health Care

Louisiana fails to provide adequate medical and mental health care to a substantial number of juveniles confined in its secure correctional system. None of the four facilities have adequate physician and psychiatrist coverage to ensure adequate medical and mental health services. The State is violating these juveniles' constitutional rights to adequate medical and mental health care while confined by failing to provide adequate screening and assessment at intake; failing to provide mental health care for a number of seriously mentally ill children at Tallulah; permitting guards to deny access to medical care at three of the four facilities; and failing to provide adequate treatment programs and a number of routine medical practices.

1. Inadequate Medical Care

The level of violence at all four facilities forces understaffed infirmaries at each facility to focus primarily on emergency medicine. In spite of the efforts of Project Zero Tolerance, medical staff at each facility continue to treat youth for a high number of injuries every day. For instance, youth at Tallulah suffered 126 documented orthopedic injuries for the two-month period from 11/23/96 through 1/23/97. In the same two-month period, at least four juveniles at Tallulah suffered perforated eardrums due to blows to the head. In each of these

four cases, the juveniles alleged that the blows were caused by officers. At Swanson, the infirmary log indicated that during the brief 20-day period between 12/10/96 and 12/30/96, at least 16 different children suffered injuries due to trauma, including at least three children who suffered two traumatic injuries during this period. At least seven of these children suffered such serious injuries that they required hospitalization for treatment. Thus, infirmary beds throughout the system, but particularly at Swanson and Tallulah, are filled with children with serious injuries, such as broken jaws and noses. In addition, with the exception of the recently-opened infirmary at Tallulah, the infirmaries at all of the facilities are located in substandard buildings that have inadequate space and facilities to meet basic sanitation and resource requirements of a health care facility. The infirmary at Swanson is particularly deficient.

Routine medical care provided at the facilities is deficient. Intake screenings and assessments are inadequate. Screening and assessment information concerning medical and mental health conditions is often incomplete and contains conflicting information; quality assurance procedures do not adequately identify these errors. Failure to identify health problems at intake results in inadequate medical and mental health care for a number of juveniles and inappropriate placement within the facilities. For example, some juveniles with mental and physical disabilities have deteriorated significantly after being placed inappropriately in Tallulah's boot camp.

At each facility, discrete deficiencies in the delivery of medical care were noted. At Jetson, the deficiencies include: 1) failure to provide adequate medical care to juveniles with disabilities; and 2) failure to track laboratory results adequately, such as the case of one juvenile who had not received treatment for gonorrhea because the facility misfiled the lab results. Staff at Jetson also reported a need for training regarding HIV.

At Tallulah, the deficiencies include: 1) denial of access to medical care by correctional staff who refuse to escort injured youth to the infirmary; 2) failure to provide adequate nursing services; 3) failure to follow medical orders regarding health conditions, such as the case of a juvenile with glaucoma who was sprayed in the eyes with mace in spite of explicit medical orders not to do so; 4) failure to review adequately laboratory results; 5) failure to provide HIV tests to juveniles who request them, such as the case of one juvenile who has repeatedly asked for but has not been tested for HIV and whose medical chart reveals at least ten sexual contacts while confined at Tallulah, including two with a guard; 6) failure to practice universal precautions; and 7) failure to provide adequate nutritional planning, such as for the thirty youth in a

segregated isolation unit, each of whom had lost five or more pounds since admission to the unit.

At Bridge City, the deficiencies include: 1) denial of access to medical care by correctional staff who refuse to escort injured youth to the infirmary; and 2) failure to have a policy regarding follow-up of laboratory results.

At Swanson, the deficiencies include: 1) denial of access to medical care by correctional staff, where children are sometimes denied permission to go to sick call with injury complaints when they are misbehaving; and 2) failure to follow the facility's HIV testing policy, which requires that a test be provided if requested, including arbitrary denial to provide the test, such as the juvenile who reported that his request for an HIV test was refused because he had not "lost enough weight."

All four facilities provide inadequate dental services, which are generally limited to extractions.

2. Inadequate Mental Health Care

The most egregious deficiencies in mental health care were noted at Tallulah, where juveniles with extensive psychiatric histories who self-mutilate and/or threaten suicide have never been referred to a psychiatrist. Tallulah employs no psychiatrist and provides no mental health care to its many youth with serious mental illness. At most, counselors who are not trained in mental health care and not supervised by mental health professionals speak to juveniles. This complete denial of necessary care is causing great harm at Tallulah.

We found numerous suicide hazards throughout the secure juvenile facilities in Louisiana. For example, at Tallulah, "rails" - horizontal bars on the second tier of some housing units - represent a serious suicide hazard. Youth at Tallulah have a practice of climbing the rails and threatening or attempting suicide. In fact, on one of our tours of the facility, our expert psychiatrist observed blood on the rails from an attempted suicide the previous day. On another expert tour of Tallulah, we witnessed two youths climb the rails, tie nooses around their necks, and threaten suicide. Although Tallulah has recently taken steps to modify the rails in response to our alerting the facility to the danger, it appears that the modifications are inadequate. We have received several recent reports indicating that youth at Tallulah continue to climb the rails and threaten to hurt themselves. The Montana unit at Tallulah has blind spots and numerous fixtures that could serve as anchors for hanging attempts. The infirmary at Jetson has many blind spots, and some patient care areas have exposed wires, outlets and knobs that provide potential for self harm. There were numerous unenclosed overhead pipes throughout Bridge City,

despite the fact that depressed and suicidal youth are specifically assigned to this facility due to their vulnerabilities.

At Tallulah and Jetson, psychotropic medications are managed inadequately. Both facilities fail to monitor for medication efficacy or side effects adequately. Tallulah has no psychiatrist to monitor the medications. In addition, both facilities fail to document consent for treatment with these medications in the medical record. Moreover, at Jetson, juveniles reported being put in isolation or being beaten for refusing to take psychotropic medications. Bridge City nursing staff abruptly stop all psychotropic medications at intake until a juvenile sees a psychiatrist. For some psychotropic medications, this is a dangerous practice that does not comport with accepted professional standards.

Mental health assessments and counseling are severely deficient at all four facilities. The mental health assessments performed at intake into the system are particularly inadequate. Because juveniles with mental health problems are inadequately assessed, they receive inappropriate treatment. At all four facilities, access to group therapy is severely limited. Individual mental health treatment plans, where they exist, fail to meet professional standards. A review of treatment plans at all four facilities revealed inadequate documentation of goals and youths' progress toward the goals. Many treatment plans were incomplete. Moreover, because an estimated 80-90 percent of the youth in these four facilities have behavior problems, facility-wide behavior management programs are necessary. The lack of adequate behavioral management programs contributes to the pervasive violence within the facilities.

Louisiana is failing to ensure that the numerous youth with mental disabilities confined in its secure correctional facilities receive appropriate treatment and training while confined and appropriate continued care upon discharge. Special training and skills programs for juvenile with mental retardation are non-existent. For instance, in August 1996, 56 juveniles at Tallulah were identified by the facility as being mentally retarded, yet, Tallulah failed to provide most of these juveniles with any special programs to address their needs.

Staff at all four facilities are not adequately trained to recognize and meet the need of youths with mental retardation and/or mental illness or juveniles with a history of substance abuse. Staff at all four facilities lack adequate training in behavioral management techniques. Staff at Tallulah acknowledged the need for training in suicide assessment, crisis management, psychiatric medications, seizure management, therapeutic techniques, and working with violent juveniles. At Jetson, the

nursing director recognized the need for expanded mental health training for nurses. Jetson nursing and counseling staff expressed the need for more information regarding psychotropic medications. At Bridge City, both the psychiatrist and psychologist identified a need for further staff training in working with youth with mental disabilities.

C. Inadequate Education and Rehabilitative Services

Louisiana law requires that all children under the age of 17 attend school. Any failure by the State to enforce its compulsory education laws in the four secure juvenile facilities must be rationally related to a legitimate penological interest. See Goss v. Lopez, 419 U.S. 565, 573-76 (1974); Donnell C. v. Illinois State Board of Education, 829 F. Supp. 1016, 1018 (N.D. Ill. 1993). In addition, federal law requires that juveniles with learning disabilities in these facilities receive special education and related services. Id. Related services means "such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education." 34 C.F.R. § 300.16 (1994).

Education services in the facilities do not comply with applicable State regulations, federal statutes, or professional standards. Our consultants concluded that the education programs in the facilities "operate completely outside the bounds of acceptable educational practice." The Louisiana Department of Education does not monitor adequately the education program at the facilities, nor does it ensure that services to children with disabilities comply with State policies regarding special education. As a result of current practices, our consultants concluded that "students are unable to maintain their academic progress, fail to develop new skills, and are no more prepared to re-enter their home communities or other institutions than when they were initially confined." In sum, Louisiana fails to provide an adequate education to youth confined in its correctional facilities.

Our consultants identified system-wide disregard of State or Department of Public Safety and Corrections ("DPSC") policies in the areas of school budgeting and finance; minimal length of school day; discipline of handicapped students; instructional material and equipment; school libraries; high school graduation requirements; program of study; and vocational programs. Most youth, if they attend school at all, do not receive a State mandated minimum 5½ hours per day of instructional time. With the exception of the juveniles under age 17 on the open campus of Swanson who receive 5½ hours per day of instruction, most juveniles receive no more than four hours a day of school.

At Tallulah, where the school is extremely overcrowded, youth attend school only three hours a day as a space saving measure. Children confined to the Phase II section of Tallulah attend a three hour daily class in the small day rooms of their living units. Little or no instruction occurs in this chaotic environment and instructional materials are not available much of the time. Moreover, throughout the system, there are some students not enrolled in school at all. For example, at Bridge City, we met one 11-year-old who had not been in school for a number of months. Instead, he spent his days cleaning the facility.

When teachers are absent, students either receive no instruction or students are distributed randomly among other classrooms, in violation of State policy mandating substitute teachers. At Bridge City, serious problems with regard to teacher absences and lack of substitute teachers are resulting in classrooms supervised by correctional officers, referred to by the children as "CSO classes." One Bridge City teacher had been out for five months earlier in 1996 while correctional officers "taught" her class. Our consultants found that no meaningful instruction takes place in CSO classes. On the contrary, the officers either monitor the children minimally or sleep. This situation is not only resulting in a failure to educate, but can result in serious harm. Several children at Bridge City reported that while an officer slept in one CSO class, a juvenile was forced to perform oral sex on another juvenile.

Our consultants concluded that education decisions appear to be driven solely by security and fiscal concerns. Throughout the system, homework is prohibited by security staff, who fear that writing utensils may become used as weapons in the dorms. In all living units except for the Phase II units at Tallulah, security staff do not even permit books, explaining that contraband can be hidden in books. Security and educational staff should work together to devise a method to allow homework and reading material on the living units that would also address security's legitimate concerns. Students also have inadequate access to library services. Fiscal limitations result in dated and limited library materials, and pay differentials between teachers in the community and teachers in the facilities result in staff turnover that adversely impacts educational services in the facilities.

The special education programs at all four facilities fail to meet IDEA legal mandates and fall far below minimum professional standards. Screening and identification of eligible youth are inadequate. For instance, three months after his confinement to State custody, a 12-year-old at Tallulah with an IQ of 68 was not yet receiving special education services. Even if a child has been identified as eligible for special education before being confined, the facilities fail to provide services

within the legally prescribed time limit. Although State and federal regulations require that students enrolled in special education transferring from one school district to another receive appropriate services within five days, students do not receive any special education services during intake and orientation - which in some cases can take months. One child at Jetson who was eligible for special education services reported that she had spent about two months in the intake dormitory without being enrolled in school. Girls in the intake dorm, she reported, "slept all day because there were no programs." Many teachers at Tallulah reported that students may be ready to leave the facility by the time the teachers can schedule special education.

At all four facilities, students do not receive adequate instructional time nor adequate related services required by IDEA to ensure that children eligible for special education benefit from the services provided. At Bridge City, federally mandated planning meetings are inadequately staffed. At Tallulah, none of the teachers is certified in special education and the four teachers providing special education services do not attend in-service training with the other special educators employed in the public schools.

Vocational education is inadequate at Jetson and Swanson and non-existent at Bridge City and Tallulah. At best, Jetson and Swanson expose the students to vocational skill areas but fail to teach rudimentary skills adequately; at worst, the vocational programs of these two facilities seriously compromise the children's' health and safety. In one case, a 14-year-old taking his first shop class lost parts of four fingers in an extremely dangerous power tool that is not appropriate for entry level shop experience. At Swanson, well qualified instructors are unable to provide instruction due to insufficient instructional materials, excessively large classes, and a curriculum driven by the maintenance needs of the institution.

The boys placed in isolation at Swanson and Tallulah receive no educational services, including special education services. Although the boys placed in isolation at Jetson receive some educational services, the girls placed in isolation at Jetson receive no such services. System-wide, the facilities fail to provide special education services to children who are administratively isolated for their own protection. Because students with emotional or behavioral disorders, including youth with serious mental health needs, are vulnerable to behavioral sanctions such as isolation, this is a serious problem.

Although one purpose of Louisiana's secure correctional facilities is to rehabilitate youth, all four facilities lack adequate youth development programs, including adequate behavior

management programs, life skills training, and adequate structured daily activities, including recreational opportunities. During non-school hours, officers force the majority of juveniles at all four facilities to spend several hours every day sitting in mandated silence in their units with nothing to read or do. We found instances where juveniles were punished or hit by officers if they spoke or shifted in their seats during these periods.

D. Other Juvenile Justice Deficiencies

1. As noted throughout this letter, inadequate staffing and poorly trained staff contribute to the unconstitutional conditions at the facilities. Officer-to-juvenile ratios are inadequate to properly supervise and care for the juveniles confined in the State's facilities.

2. Overly-restrictive practices with respect to mail, telephone, and visitation work together to deny juveniles in all four facilities the ability to communicate and associate with their families and communities. For instance, many youth alleged that a limit exists on the number of letters that can be mailed, even for those youth who pay for all associated costs. At Bridge City, juveniles stated they could only write letters on Sunday. No facility allows children more than two outgoing calls weekly, except for emergencies. Children at all four facilities are prohibited from taking incoming calls. We observed broken telephones at Tallulah where juveniles reported that the telephones had been broken for several weeks before our tour. All four facilities fail to provide adequate visitation opportunities. Visitation is permitted only one Sunday each month. Many juveniles stated that their placement in facilities far from home, combined with such limited visitation rights, caused families to be unable to visit. The State offered no justification for its restrictions on family contact. In sum, the facilities' limitations on mail, telephone access, and visitation estrange juveniles from their families instead of strengthening family ties that increase the likelihood that the juvenile will succeed after release.

3. All four facilities fail to provide adequate access to juveniles with physical disabilities who are confined to wheelchairs. For instance, a disabled juvenile confined to a wheelchair at Jetson must go to the infirmary in order to bathe or to use the bathroom. One of our investigators was also confined to a wheelchair and could not gain access to a number of buildings at Bridge City and Jetson.

4. Louisiana fails to provide adequate and meaningful access to courts and counsel to juveniles confined in its correctional facilities. The State fails to provide appropriate

assistance to juveniles to pursue direct appeals of their adjudication, collateral attacks on their confinement, and claims regarding unconstitutional conditions of confinement and other civil rights claims relating to confinement. In 1996, the State admitted 1900 youth for incarceration in the four facilities. Although the vast majority of these youth were represented by public defenders, there are only 10 reported cases of direct appeals by juveniles represented by public defenders. Although the State has an administrative grievance procedure that juveniles must exhaust before filing complaints in court, the procedure is overly complex and no meaningful assistance is provided. Most juveniles we interviewed regarding their options for complaining about conditions of confinement were unaware of the administrative procedure.

II. MINIMUM REMEDIAL MEASURES

To rectify these deficiencies and to ensure that Louisiana's secure correctional facilities for juveniles comply with federal constitutional and statutory requirements, the following minimum remedial measures must be implemented in addition to those set forth in our July and October 1996 letters to you:

1. Adequately protect juveniles in the facilities from staff abuse and juvenile-on-juvenile violence. Employ sufficient trained, independent investigators, to ensure that all incidents of violence, use of force, or serious injury are adequately investigated. Ensure adequate investigatory procedures. Ensure that all juveniles have direct, reasonable access to the Project Zero Tolerance hotline.

2. Ensure that juveniles are classified and housed adequately to protect them from harm. Develop and utilize appropriate placements for juveniles with mental disabilities and other special needs.

3. Ensure that restraints and isolation are used only when a youth presents a clear and present danger. Provide adequate positive behavior management programs.

4. Employ sufficient trained staff to ensure the safety and to satisfy the individual treatment, training, and rehabilitative needs of juveniles confined in these facilities.

5. Train existing staff to allow them to perform their positions adequately and ensure that all staff demonstrate an understanding of and/or demonstrate the application of these skills. For all staff working with juveniles, the areas of training and demonstrated competence should include: passive restraint; stages of adolescent development; communication skills; therapeutic intervention skills; basic rights of

residents and staff; report writing; basic medical terminology; recognizing and responding to seizure disorders; common side effects of prescription and non-prescription medication; the physical and emotional needs of pregnant residents (for staff working with female juveniles); universal precautions to prevent infection of TB and AIDS; the prevention and management of suicidal behavior; confidentiality of medical information; the provision of health education for residents; basic information concerning learning disabilities; certification in first aid and cardiopulmonary resuscitation; and adaptive activities for physically and developmentally challenged juveniles.

6. Provide adequate mental health care, medical care, and dental services to juveniles confined to the four secure care facilities and a sufficient number of qualified staff to provide the services.

7. Take adequate suicide prevention measures, including removal of suicide hazards, and adequately supervise suicidal juveniles.

8. Provide adequate and appropriate general education and special education services to juveniles confined to the four secure care facilities. Provide adequate and appropriate vocational programs with work that is related to the purpose of treatment and rehabilitation. Ensure that female juveniles receive the same level of educational services as male juveniles.

9. Provide appropriate activities during non-school hours and days. Provide juveniles with adequate and appropriate opportunities for exercise, recreation, and reading materials.

10. Provide juveniles with adequate access to telephone, mail, and visitation.

11. Make the facilities accessible for juveniles with physical disabilities.

12. Ensure juveniles' meaningful access to courts during confinement for direct appeals, collateral attacks on their confinement, and cases related to unconstitutional conditions of confinement and other civil rights claims relating to confinement.

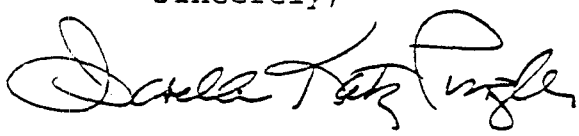
13. Provide juveniles with adequate transition and aftercare services.

14. Develop and implement adequate quality assurance mechanisms and reviews to ensure the efficacy of corrective measures.

Finally, because conditions at the four facilities are before the court in Williams v. McKeithen, CA 71-98-B (M.D. La.), we are providing a copy of this letter to the court and counsel of record in that case.

Pursuant to CRIPA, the Attorney General may initiate a lawsuit to correct deficiencies at an institution 49 days after appropriate local officials are notified of them. 42 U.S.C. § 1997b(a)(1). Under the pattern or practice provision of the Violent Crime Control and Law Enforcement Act of 1994, the Attorney General may initiate a lawsuit to correct the deficiencies. 42 U.S.C. § 14141. We therefore look forward to conducting negotiations with the State of Louisiana to resolve the existing systemic deficiencies. We look forward to working with you and other State officials to resolve this matter in a reasonable and expeditious manner.

Sincerely,



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