U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General *Washington, D.C. 20035*

OCT 3 1996

BY OVERNIGHT MAIL

CRIPA Investigation

JI-LA-001-010

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

Re: Investigation of Secure Correctional Facilities for Children in Louisiana Children in Louisiana

Dear Governor Foster:

As you know, we are currently investigating conditions at the secure correctional facilities for children in Louisiana. Following our June tours of two of the facilities, Louisiana Training Institute at Bridge City and Jetson Correctional Center for Youth, we notified you on July 15, 1996 that we had uncovered serious systemic problems with staff abuse and juvenile-on-juvenile violence at these two facilities. Given the gravity of the situation, we asked the State to begin addressing these dangerous conditions immediately.

As we have found at every step of this investigation to date, the State responded in a prompt and cooperative manner. Within days of our July 15th letter, your Executive Counsel and your Secretary of Corrections contacted us with their offer to meet to discuss Louisiana's response to our interim findings. On July 30, 1966 the State presented its response to our findings, "Project Zero Tolerance," which incorporated a number of the recommendations for immediate action that we made in our July 15th letter. Notably, the State took the admirable initiative of implementing Project Zero Tolerance statewide rather than limiting it to the two facilities addressed in our July 15th letter. Although not all of our recommendations were incorporated in Project Zero Tolerance, we agreed that the Project should go forward, on the condition that it may need revisions or additions based on our continuing investigation. The State launched Project Zero Tolerance on August 1, 1996.

Because State officials at all levels have expressed their desire to work with us in the event that our investigation revealed problems in the system, we again take the unusual step

of writing to you to report additional interim findings based upon our August investigation of the two remaining facilities, Louisiana Training Institute at Monroe and Tallulah Correctional Center for Youth. Our most recent tours revealed life-threatening and dangerous conditions in these facilities that are similar to conditions we found in June at Bridge City and Jetson.

We toured Monroe and Tallulah during the weeks of August 19 and August 26. At the end of both tours, we notified facility officials that we uncovered serious systemic problems with staff abuse and juvenile-on-juvenile violence at each facility. In both cases, we also provided names of juveniles whom we felt were at particularly high levels of risk. A few examples of the type of evidence that we discovered include:

* At both Monroe and Tallulah (as we had previously found at Bridge City and Jetson), almost each of the more than 100 children we interviewed spoke of being hit and/or kicked by officers and seeing other children being hit and/or kicked by officers. Children reported being assaulted by officers for such minor offenses as talking, not running fast enough, and not walking in line. Several juveniles at Tallulah described how a guard crushes their testicles with his outstretched arms during routine spread-eagle searches. A juvenile at Tallulah described how a guard punched, choked and hit him on the head with a radio for failing to put his tee shirt on properly. When the child "balled up" on the ground to signal that he was not fighting back, the officer kicked him in the face and head and maced him. At Monroe, a child reported being hit on the head with a padlock, causing a laceration requiring sutures, merely because he was turning the faucets on a sink on and off. Similarly, a Monroe juvenile reported that an officer hit him on the head with handcuffs, causing a laceration requiring multiple stitches. Another Monroe juvenile reported that as he was lying on the ground after a fight between juveniles, a guard ran up and kicked him in the face in front of several witnesses, breaking his nose. A number of juveniles alleged that officers hit them once they are restrained in handcuffs and defenseless.

* Guards at both Monroe and Tallulah allegedly avoid detection for abuse by taking a juvenile to areas where cameras will not record their actions. At Tallulah, we received reports that guards take children, alone or in groups, into the "cut," the area underneath the cameras and thus out of viewing range, where the children are assaulted. For instance, a Tallulah juvenile reported that a guard took him into the cut and assaulted him

for failing to complete a series of exercises. When the juvenile reported the incident to supervisory correctional personnel, the guard threatened the safety of the juvenile's family and stated that other juveniles were going to jump him in retaliation for reporting the abuse. At Monroe, even though there are cameras in the closed campus dorms, guards allegedly also take children into areas not monitored by the cameras to assault them.

* At both Monroe and Tallulah, misuse and overuse of chemical and mechanical restraints and isolation contribute to a culture of violence within the facilities. For example, children are isolated in solitary confinement for extended periods of time for minor disciplinary infractions or even for suicide attempts. Moreover, guards using chemical restraints at each facility are exerting excessive force on the juveniles. At Tallulah, records indicate that juveniles are maced for such minor infractions as cursing at correctional staff, kicking the door to their rooms, refusing to get off of the telephone, and refusing to go into their rooms. A Tallulah juvenile with glaucoma was recently sprayed with mace in spite of a medical order indicating that the juvenile had had eye surgery and should not receive any chemicals or trauma which could cause blindness. At both Monroe and Tallulah, juveniles reported being maced long after a fight is broken up -- some while their hands are cuffed behind their backs. While we toured Monroe, a child who had been placed in handcuffs for throwing water on a guard was subdued and standing still when a Lieutenant arrived on the scene and maced him with <u>two</u> cans of spray. Another Monroe juvenile reported that, following a fight that was broken up by guards, he was lying face down with his hands cuffed behind his back when a Lieutenant arrived on the scene, ordered him to stand, and proceeded to mace him. A day before our tour of Tallulah began, a guard broke up a fight between two juveniles. We received reports that two additional guards entered the room and each sprayed a juvenile with mace while pushing, punching, kicking and slapping him. The juvenile was sent to the hospital for sutures to close his head wound resulting from the staff abuse.

* At both Monroe and Tallulah, children who had sustained serious injuries at the hands of other children reported being "snooked" or "snuck" (being assaulted by surprise by other offenders whom they did not know well or with whom they had no known grievance).

At both Monroe and Tallulah, juveniles report that juvenile-on-juvenile assaults are often set up by the guards who seek to teach the victim a lesson. Juveniles at Monroe spoke of a "sixty," which is a guard's promise to give a child a package of sixty cookies if the child can injure another child badly enough to require hospitalization. In other cases, juveniles report that peers receive chips or cigarettes from guards to complete a "hit." When one juvenile first arrived at Monroe and aggravated a guard, the guard made the child stand alone under the TV at the front of the dorm. A large juvenile whom the child did not know approached him and choked him until he lost consciousness. As he resumed consciousness, the large juvenile began hitting the victim's head on the floor. Another Monroe juvenile describes getting "snooked" by another juvenile he did not know; the child's eye socket was broken and required surgery.

* At both Monroe and Tallulah, juveniles report that guards allow offenders to fight with other offenders without intervening. At Tallulah, this practice is known as "opening the cut," the "cut" being the area out of camera range at the front of the dorms. Some Tallulah juveniles further reported that guards order juveniles to fight with each other, threatening beatings by guards for failure to fight. One Tallulah juvenile described a practice known as the "valley of death," where guards require juveniles to stand in a letter U formation and force a juvenile to walk into the "valley," where the child gets punched by the other juveniles.

* At both Monroe and Tallulah, we uncovered a number of egregious behavioral control techniques -- amounting to gross abuse -- being used by guards. For instance, at Tallulah, a number of juveniles described an initiation rite allegedly practiced by a guard in one dorm. On the first night that the guard works after a child is assigned to the dorm, the child is taken to the showers and out of camera range, where his arms are held by his peers while assuming a spread eagle position against the wall. The guard pulls the child's pants down and whips him with a leather belt several times. The child is threatened with a worse beating or group punishment for the entire dorm if the child seeks medical attention from the infirmary for the beating or reports the abuse to anyone else. Another guard routinely witnesses the initiation rite. A number of juveniles at Tallulah also reported that this same guard also conducts "initiations" by ordering juveniles on the units to beat up the new juveniles in the shower.

* Documented injuries at both Monroe and Tallulah confirm the seriousness of the level of violence in both facilities. From July 1 through August 19, 1996, 24 juveniles at Monroe were confined for at least one night in the infirmary for serious injuries caused by assaults from other offenders or from staff. Ten were injured so severely that they required stays of seven days or longer. During that period, ten children suffered fractures to the jaw, eye socket, nose, hand or ankle. During that same period, five children suffered serious eye injuries and one child was placed in the infirmary for injuries attributed to anal rape.

* Although serious injuries were a common problem at all of the four Louisiana juvenile facilities we toured, the frequency and seriousness of injuries was the greatest at Tallulah. On the day we arrived at Tallulah, there were three juveniles in the infirmary with broken jaws and two with broken noses. In the first 20 days in August following initiation of Project Zero Tolerance, 28 Tallulah children were sent to the hospital for evaluation and/or treatment of serious injuries, including fractures or suspected fractures and serious lacerations in need of suturing. One child suffered a laceration to his penis of "unknown" origin. Medical personnel reported that they saw a juvenile with a perforated eardrum about every two weeks and that on one particular occasion, the physician saw <u>eight</u> ruptured eardrums in one day. Almost all of these injuries were attributed to staff assaults or juvenile-on-juvenile violence.

* While a recounting of the aggregate injury statistics at Tallulah reflects the pervasiveness of the violence, an examination of the underlying incidents reveals the physical and emotional costs. For instance, one 14 year old at Tallulah is severely depressed and taking psychotropics for his depression. In May, he reported to the infirmary, stating that while he was in the bathroom, another offender grabbed him and held him and choked him. He lost consciousness and when he woke up, he stated that his pants had been pulled down. A medical exam at Tallulah confirmed anal rape, but the boy was not referred for any rape counseling. Days before we arrived at Tallulah, this same boy was involved in an offender fight. A nursing assessment found a laceration to the left side of his nose, a discolored left eye, scratches on both sides of his neck, a swollen jaw and a purple area on the base of his neck. The child was sent to the hospital, where staff confirmed a fractured nose and an injured jaw.

* At both Monroe and Tallulah, children repeatedly stated that they were afraid to report staff abuse because of the possibility of retaliation. Many non-correctional staff disclosed that offenders often misrepresent the cause of injuries due to staff abuse because the children feel that telling the truth would only subject them to more abuse. In many instances, children are allegedly coerced by guards not to seek medical attention for injuries suffered from staff abuse with threats of further abuse. Furthermore, internal investigations of alleged assaults at both facilities are seriously flawed. As a result, almost none of the abuse allegations filed by children are ever adequately investigated, leaving juveniles without faith in the process and little incentive to come forward to report abuse.

In addition to the concerns raised by evidence of continued systemic staff and juvenile-on-juvenile abuse at both Monroe and Tallulah, we uncovered evidence of certain medical and mental health problems at the facilities that pose serious risk of harm and thus necessitate immediate remediation. These conditions include:

* Tallulah lacks adequate suicide prevention measures/plans in the Java unit. The Java unit, which houses 80 of the most aggressive juveniles in the system, is ringed with metal pipes that present serious hanging risks to juveniles with suicidal tendencies. Furthermore, Tallulah has absolutely no plan in place to address emergencies created when juveniles attempt to hang themselves from these rails. An incident that occurred in the presence of Justice Department representatives illustrates the point. On August 22, 1996, while Justice Department representatives were interviewing juveniles confined in Java Unit D, two juveniles climbed to second tier railing and tied nooses around their necks. While the guards attended to the two juveniles at risk of hanging on the upper tier of the unit, the remaining juveniles in the unit were left unattended with Justice Department representatives on the floor below. The juveniles on the floor grew increasingly agitated and aggressive. Seeing this, the guards abandoned the children in nooses and came down to put the remaining juveniles in their cells. Only after all the remaining juveniles were in their cells and the guards had returned to the two children in nooses still suspended from the rails did additional correctional staff appear. The officer in the control room failed to call immediately for additional staff to help with this crisis.

* Both facilities fail to respond to juveniles' requests for HIV testing. For instance, a Monroe child's infirmary record contained a note the child had written requesting a test for HIV, stating that he had had sex with another boy known to have many partners. As far as can be determined from the child's medical record, he was never afforded a test, counselling, or even any contact from staff regarding his note. A juvenile at Tallulah discussed his multiple sexual partners, including two episodes of anal intercourse with a guard. An incident report exam indicates that on one such occasion, the juvenile had a rectal tear. The juvenile reported that he requested a test for HIV but had not received it yet.

* Tallulah staff and juveniles are not practicing universal infection control precautions when there is an exposure to blood. For instance, during our tour, a Justice Department representative pointed out a significant amount of dried blood on a living unit and was informed by staff that on the previous day, a juvenile had attempted to commit suicide. The blood was finally removed when a guard ordered a juvenile to clean it up. The juvenile proceeded to do so without any gloves to protect him from possible contamination from such serious infectious diseases as Hepatitis B.

* The staff at Tallulah do not provide adequate medical treatment to juveniles with serious asthma conditions. Medical staff and medical records confirmed that staff routinely deny juveniles with asthma problems access to immediate medical care. Moreover, the facility fails to provide timely medical/nursing assessments for asthma and fails to refer juveniles with serious asthma problems for appropriate physician intervention. For instance, a juvenile with serious asthma is in Tallulah's physically demanding boot camp program. The medical chart of the juvenile indicates that he had complained of shortness of breath on at least twenty-three different occasions since May 27, 1996. The facility's physician was never informed of the frequency of his medical complaints.

Necessary Remedial Measures

Because of the seriousness of the level of violence that we found in both Monroe and Tallulah, even after the initiation of Project Zero Tolerance, it is apparent that the efforts instituted to date have either not been sufficient to prevent a pattern and practice of abuse at the facilities or have not been effectively implemented at the facilities. It is therefore critical that the State take additional immediate preliminary

remedial measures to fully enforce Project Zero Tolerance and swiftly correct these life-threatening and dangerous deficiencies. Moreover, the State should take immediate action to address the dangerous medical concerns we identified. In particular, the State and any facility under contract with the State should immediately implement the following remedial measures:

1. As soon as possible, but in no event later than November 1, 1996, the State must ensure that independent and trained investigators are assigned to work on-site at each facility. The investigators should report to and be supervised by Major Gary McDonald and Dr. Cecile Guin of Project Zero Tolerance. These investigators must review and investigate all incidents of serious injury and all allegations of abuse, neglect, mistreatment or use of force. The investigators must have the independent authority to interview children and initiate investigations without the prior approval of the facility administrators. Initially, these investigators should be assigned at a ratio of 1:250 incarcerated youth per facility. The adequacy of this ratio should be re-evaluated after six months.

2. At Tallulah, the closed circuit camera system should immediately be expanded to ensure that all areas of the housing units (including the Java unit, which presently has no cameras) have auditory and visual monitoring and videotaping with simultaneous audiotaping on a twenty-four hour basis. All videotape of unusual incidents should be made available immediately to the investigators described in the above paragraph and the facility should retain all videotapes for a minimum period of six months.

3. Immediate steps should be taken to ensure weekly unannounced visits to all infirmaries by Central Office nursing personnel. During these visits, Central Office nurses should review injury, accident, use of force and other unusual incident reports as well as medical records and photographs of injuries with attention to the possible abuse, neglect, or mistreatment of children, and interview the children, if appropriate. These nurses should issue a monthly report of their activities to the State, the Department of Justice, the Project Zero Tolerance Task Force, and to the investigators described in paragraph one, above.

4. The State should conduct criminal background checks (checking with the National Crime Information Center, State police, local district attorneys' offices, and the Louisiana child abuse registry) on all existing staff and future staff by November 15, 1996 and take appropriate action to protect the welfare and safety of juveniles based upon information obtained from the background checks.

5. To address the excessive use of force, immediate steps should be taken to ensure that within three months, all current staff are trained and certified in an appropriate passive restraint training program. All new staff who have contact with youth should be required to attend initial restraint certification training before working within the institution, followed by a yearly re-certification for all staff. In conjunction with the passive restraint training and certification program, the State should develop and implement a Standard Operating Procedure delineating acceptable restraint methods.

6. The State must re-evaluate its decision to use chemical restraints in juvenile facilities. At a minimum, the State should develop and implement a uniform policy regarding the use of chemical restraints which permits the use of chemical restraints only in an extreme emergency situation to temporarily incapacitate an actively dangerous person. In no event may a chemical restraint be used as punishment, discipline, retaliation, or to inflict pain.

7. The State must ensure that all of its juvenile training schools immediately cease using isolation and mechanical restraints for punishment, discipline (with the exception of incidents involving battery, riot, or escape), or convenience of staff. Isolation or mechanical restraints should be used only to control behavior that poses a clear and present danger and where all other less restrictive and less invasive techniques have failed. The State must develop and implement procedures to ensure that whenever staff place a juvenile in isolation or mechanical restraints, appropriate staff adequately monitor the condition of the juvenile, record essential information, and make referrals for mental health evaluation and treatment when warranted. In no event should a facility place an actively self-injurious juvenile in isolation. All efforts should be made by staff to assist the juvenile in regaining control of his/her behavior so that isolation or mechanical restraints may be lifted at the earliest possible time.

8. Except for use in transporting juveniles, where the use of handcuffs and leg shackles may be necessary, the State must immediately ensure that the only approved means of mechanical restraint is the use of handcuffs. Handcuffs should only be used to control aggressive or assaultive behavior that is a clear and present danger to the resident, another resident, staff, or the security of the facility. The use of handcuffs should be limited to the minimum period of time necessary to enable the juvenile to gain control of his behavior. A staff person should remain with the handcuffed juvenile and should have no duties or responsibilities other than the supervision of the juvenile. The staff person should ensure that the physical needs of the juvenile are met promptly. The handcuffs should be applied behind the back in a manner to minimize the risk of injury to the

resident and staff person responsible for supervising the resident. In no event may handcuffs or other mechanical devices be used to bind a juvenile's wrists to his ankles. The juvenile should be taken to the infirmary as soon as possible after application of handcuffs for medical examination.

9. The "rails" in the Java units at Tallulah must be modified within one month to alleviate the suicide/injury risk. A crisis protocol should be put in place immediately at Tallulah to manage suicide attempts and suicide gestures, including threats of self-harm. The protocol should include training of guards, provisions for assistance during crisis by social workers and counselors, and a list of individuals who must be alerted during a suicide attempt or suicide gestures, including threats of self-harm.

10. A protocol should be put in place immediately at Tallulah to ensure that universal infection control precautions are implemented whenever there is a risk of exposure to blood and other potentially infectious materials. The protocol should include training of guards and juveniles on the use of these precautions.

11. The State should immediately ensure that any juvenile who requests a test for HIV be given the test and its results promptly.

12. The State should immediately ensure that any juvenile at Tallulah with asthma is provided with appropriate medical care.

Given the urgency of addressing these deficiencies, we will contact your Executive Counsel within the next week to discuss the remedial measures in greater detail and the State's willingness to take immediate corrective action. We believe that the results of our investigation at all of the facilities provide a basis for action pursuant not only to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997, et seq., but also appear to constitute a violation of the Police Misconduct Provision of the 1994 Crime Bill, 42 U.S.C. § 14141. However, because the State has expressed its desire to cooperate in this investigation and we would prefer to address the dangerous deficiencies swiftly and without resort to litigation to obtain necessary relief, we make this offer to jointly address the deficiencies in the most expeditious manner.

Sincerely,

Deval L. Patrick
Assistant Attorney General
Civil Rights Division

cc: The Honorable Cheney C. Joseph, Jr.
Executive Counsel to the Governor

The Honorable Richard Ieyoub
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