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Civil Rights Division

Office of the Assistant Attorney General

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Registered Mail
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The Honorable Raphael Hernandez-Colon
Governor
Commonwealth of Puerto Rico
La Fortaleza
San Juan, Puerto Rico 00901

Re: Investigation of Juvenile Facilities In the Commonwealth of Puerto Rico

Dear Governor Hernandez-Colon:

I am writing in reference to our investigation into conditions within seven juvenile facilities in Puerto Rico pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. §1997 et seq. From May 28, 1991, through June 3, 1991, we visited the Juvenile Detention Center of San Juan in Hato Rey, the Industrial School of Mayaguez, the Juvenile Detention Center of Ponce, and the Center for Social Treatment of Ponce. Additionally, from October 21-23, 1991, we visited the Industrial School for Boys and Girls in Ponce, the Juvenile Detention Center in Humacao, and the Central Treatment Center in Guaynabo. Consistent with the requirements of the statute, the purpose of this letter is to advise you of our findings by identifying the conditions at the seven facilities that deprive the juveniles confined there of their constitutional rights, the facts supporting our determination of constitutional violations, and the necessary remedial measures to correct these violations. I regret to advise you that our investigation disclosed serious problems which implicate the constitutional rights of confined juveniles.

We have assessed the constitutionality of conditions of confinement at the seven facilities in light of a narrow constitutional standard. Institutional administrators are granted wide discretion in the operation of a facility; only those restrictions on juveniles which do not further or are not reasonably related to the legitimate government objection of rehabilitation, safety, internal order or security violate constitutional standards. Harsh conditions which are unrelated to these objectives constitute punishment without due process of

law and as such may not be inflicted upon juvenile detainees. Bell v. Wolfish, 441 U.S. 520, 539 (1979); Santana v. Collazo, 714 F.2d 1172, 1179-81 (1st Cir. 1983), cert. denied, 466 U.S. 974 (1984).

Based upon our extensive investigations, we have concluded that conditions in the above-mentioned juvenile facilities deprive juveniles confined in them of their constitutional rights. In all facilities, these conditions include:

1) The presence of fire safety hazards.

In all facilities except the Central Treatment Center in Guaynabo, these conditions include:

2) The lack of adequate medical care and mental health services.

3) The presence of unsanitary and unsafe conditions throughout the facilities.

4) The absence of sufficient beds and/or mattresses for juveniles to sleep on.

5) The lack of proper mechanisms to identify, investigate, and implement remedial measures, if necessary, regarding abuse of juveniles and sufficient security measures to control institutional violence among juveniles.

6) The absence of constitutionally required periods of exercise.

The Attachment to this letter sets forth the facts supporting the findings of constitutional violations.

Remedial measures must be taken to ensure that juveniles confined to these facilities are not deprived of their constitutional rights. These measures must include, at a minimum, the following remedies:

1) Fire safety hazards must be eliminated. The Commonwealth must institute, as soon as possible, adequate fire safety practices and procedures, including those for emergency evacuation. Sufficient functional fire-safety equipment to ensure a safe environment must be provided and staff must be trained in its use.

2) A medical delivery system must be developed and implemented which is able to identify, treat, and manage the acute and chronic medical care needs, including the serious mental health needs, of juveniles. This system may include the reliance on outpatient care facilities, inpatient facilities, or both. If outpatient facilities are to be utilized in a significant manner, the Commonwealth must ensure that such facilities can meet the medical care needs of juveniles identified by Commonwealth officials to be met by such facilities.

3) Unsafe and unsanitary conditions throughout facilities must be eliminated.

4) Adequate sleeping facilities must be provided to all juveniles.

5) Proper mechanisms and procedures to identify possible abuse of juveniles, fully investigate such allegations, make proper findings, and take appropriate action should abuse be found to have occurred, must be developed and implemented.

6) Policies and procedures for the maintenance of security in these facilities must be reviewed and revised, as necessary. Staffing, procedures for the assignment of juveniles to and within facilities, methods for managing crowded conditions, and training of security guards require significant enhancement.

7) Opportunities for periods of exercise which satisfy constitutional standards must be afforded.

You may wish to contact the regional offices of the Department of Health and Human Services and Education as well as the National Institute for Corrections to ensure that Commonwealth officials have taken full advantage of any available federal financial assistance which may be available to assist in the correction of these deficiencies. If we can assist you in this regard, please contact us.

We appreciate the assistance and cooperation that representatives of the Commonwealth and the facilities have extended to us during this investigation. My staff will contact appropriate officials in the near future to discuss this matter further. In the meantime, should you or your staff have any

questions regarding this matter, please feel free to call Arthur E. Peabody, Jr., Chief, Special Litigation Section, at (202) 514-6255.

Sincerely,

John R. Dunne
Assistant Attorney General
Civil Rights Division

Enclosure

cc: The Honorable Rafael Pont
Deputy Attorney General
Commonwealth of Puerto Rico

Daniel F. Lopez-Romo, Esquire
U.S. Attorney

Luis Rivera-Roman, Esquire
Advisor on Security Affairs

Dr. Mercedes Cintron, Administrator
Administration of Social Services

Mrs. Paulita Diaz de Vasquez, Director
Juvenile Detention Center of Ponce

Mr. Miguel Pacheco, Acting Director
Center for Social Treatment of Ponce

Mr. Luis Acevedo Rodriquez, Director
Mayaguez Correction School

Mrs. Lydia LaSalle, Director
Juvenile Detention Center of San Juan

Mrs. Elia Vega, Director
Industrial School for Boys and Girls

Mr. Julio Cualio Bonet, Director
Social Treatment Center in Guaynabo

Mr. Hector Garcia, Director
Juvenile Detention Center in Humacao

Summary of Findings Regarding Conditions at the Juvenile Facilities in Puerto Rico

Our investigation consisted of two separate tours of seven juvenile facilities in the Commonwealth of Puerto Rico -- (1) the Juvenile Detention Center of San Juan in Hato Rey; (2) the Industrial School of Mayaguez; (3) the Juvenile Detention Center in Ponce; (4) the Center for Social Treatment in Ponce; (5) the Industrial School for Boys and Girls in Ponce; (6) the Juvenile Detention Center in Humacao; and (7) the Central Treatment Center in Guaynabo. Our expert consultants included: a penologist expert in juvenile detention facilities, a fire-safety expert, and a physician. The institutions visited were either diagnostic facilities, where youth undergo pre-placement evaluation, or training centers to which they are subsequently transferred for care, education, and training. We observed conditions at the various institutions, interviewed administrators and staff, and examined voluminous documents regarding the overall operation of these facilities.

The following is a summary of our findings and opinions of our consultants regarding conditions at these juvenile institutions. These findings and opinions relate to conditions we have determined to be constitutionally deficient. The first finding, regarding fire safety, applies to all seven facilities. The remaining findings apply to all facilities except the Central Treatment Center in Guaynabo.

1. Fire Safety. All facilities use highly flammable polyurethane mattresses. Our fire consultant concluded that the use of these mattresses at all facilities visited, coupled with crowded cell conditions, places the juveniles at serious risk of physical harm or death should a fire break out. Such mattresses produce toxic gas when burned. Exposed wiring exists throughout all the institutions. In one facility, a live wire dangled from the ceiling near the recreation area adjacent to a bathroom.1/ At another facility, live wires hung from an area where there had been a drinking fountain and exposed wires had been dangerously connected together to turn on overhead lights. Throughout the facilities, our expert also found inoperable fire fighting equipment and the improper storage of combustible materials.

Indeed, our consultant found the facilities to be so dangerous that it was his opinion that serious loss of life would occur in the event of a fire. Antiquated structures, the lack of proper evacuation procedures, the inability to unlock cells

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1/ Our consultant concluded that the risk of multiple fire-related deaths at this facility, the Juvenile Detention Center of Ponce, was so serious that he drafted a letter to this effect and handed it to the facility's director during the tour.

without the use of individual keys, the lack of proper fire fighting equipment and the lack of preparedness all contribute to this dangerous condition.2/

Finally, staff training in all areas of fire prevention was found to be virtually nonexistent. Fire drills and the testing of fire equipment occur rarely, if at all. These overall fire safety deficiencies pose a serious threat to the safety of both the staff and juveniles.

2. Inadequate Medical Care. Our medical consultant concluded that the Commonwealth is failing to provide adequate medical care to juveniles. Indeed, the deficiencies noted are so basic and so pervasive that our medical consultant concluded that the delivery of medical services is so poor as to be tantamount to having no medical care system at all. The current medical care delivery "system" can neither identify juveniles in need of treatment, nor ensure needed treatment is afforded. As a result, juveniles are exposed to grievous harm.

Absent any real medical care delivery system, juveniles with broken bones, injuries from physical assaults from both juveniles and guards, and other serious medical conditions fail to receive medical care. Our consultant observed a number of extreme examples of the failure to deliver needed medical care, including one juvenile with an exposed leg wound which appeared to be gangrenous, another who suffered an asthma attack absent any medical intervention whatsoever, and a number of juveniles covered with insect bites from head to toe.

Serious deficiencies begin during the intake process. The initial physical examination of the juveniles is often delayed beyond any reasonable time. Our expert noted numerous examples of juveniles who had not been examined on entrance or scheduled for examination even when they exhibited obvious medical problems. The absence of proper intake procedures permits potentially serious conditions to go undetected and untreated.

Furthermore, daily medical services at all facilities visited are also completely deficient. Untrained staff, not physicians and nurses, make initial discretionary decisions as to who may visit the doctor. On too many occasions, juveniles are not permitted to see a doctor because there is inadequate security staff to escort the juvenile to the clinic. Moreover, physician coverage is seriously deficient. All physicians

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2/ Locked cell doors contributed to the deaths of two juveniles in a fire in Hato Rey in 1988. In another 1988 incident, locked cell doors contributed to the death of a resident at the Center for Social Treatment of Ponce who had set his mattress on fire.

currently employed work only part-time schedules. In these circumstances, access to a doctor is regulated by the presence of a physician and physicians' schedules, not the needs of the individual juvenile. A shortage of nurses serves to further exacerbate medical care deficiencies.

At all facilities, shortages of staff have resulted in inadequate medical documentation as well. Those few physicians providing medical services rely on the nurses to compile the juveniles' medical file. Nurses repeatedly reported to our medical consultant, however, that they do not have the time to complete documentation routinely required by any known medical standard. Thus, medical care is seriously compromised even in those cases where a physician sees a juvenile because documentation is not sufficient to permit the physician to exercise informed professional judgment based on the history of the individual case.

Medication deficiencies are widespread throughout the facilities. Frequently, juveniles are taken off all medications upon intake, irrespective of their kind or purpose, without any subsequent medical review to determine their need. Medications given after 9:00 p.m. when no medical personnel are present are dispensed by correctional guards. There is evidence that many of the prescribed medications are actually not given to juveniles. At Mayaguez, we were given unopened medication packets identifying the juvenile for whom the medication had been prescribed and the time for administration which had passed. We were advised that these medications had been discarded and not given as directed by the attending physician. Medication logs failed to record the failure to administer these prescribed medications.

There are no medical personnel on duty after 9:00 p.m. Juveniles receive medical attention only in situations of acute emergency. Our consultant found emergency care procedures to be especially deficient. Those facilities in more remote areas, such as Humacao, Mayaguez, and the Industrial School for Boys & Girls in Ponce, lack any capacity, including an ambulance, to transport juveniles in emergency circumstances to adequate hospital facilities in a timely manner.

Our medical consultant further determined outpatient treatment to be deficient. Due to the lack of inpatient facilities, there is extensive reliance upon community hospitals. However, the same problems -- lack of identification of serious medical problems of juveniles requiring care beyond the institution's capacity, failure to refer juveniles with urgent medical difficulties in a timely manner, inability to ensure that the juvenile actually is transported in a timely manner to the outpatient facility or receives the prescribed treatment, and

deficient follow-up care -- impede access by juveniles to needed outpatient medical services and adequate medical care.

In sum, our medical consultant concluded that these facilities lack a medical care delivery system which is capable of providing adequate medical care to juveniles.

3. Inadequate Mental Health Services. As a result of the lack of psychiatric services within the facilities and the refusal of most outpatient clinics and hospitals to treat juveniles committed to these facilities, juveniles in need of mental health services to meet their serious needs do not receive adequate psychiatric care and treatment. Moreover, even those few outpatient facilities which are willing to admit these juveniles place such limitations on the treatment they will provide that the care remains inadequate. As with medical services, there is no system in place for the provision of mental health care to juveniles.

As a result of such failure to provide adequate mental health services, there is regrettably a record of both suicides and suicide attempts at these facilities. Moreover, our medical consultant identified individuals who had attempted suicide who were, nonetheless, not receiving any mental health care whatsoever.3/ Further, it is not standard practice to assign staff to monitor such individuals or to take other general precautions to prevent further suicide attempts. Finally, it was the opinion of our medical expert that the use of psychotropic medications at these facilities is dangerous and substantially departs from generally accepted medical standards and practice for the use of such drugs.

4. Inadequate Physical Facilities and Unsanitary, Unhealthful Environment. The physical conditions under which the juveniles live are unsanitary and pose serious health and safety risks. General unsanitary conditions were observed at all the facilities. Litter and other debris were strewn throughout the living units at these facilities as the juveniles, some living four to five to a filthy cell, sat in pools of water which had leaked from the plumbing. Rat and insect infestation was also present throughout the facilities.

Food preparation and delivery is likewise unsanitary and unsafe. In many cases, food is not properly cooked. In a particularly noteworthy incident, our consultant discovered that

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3/ At Mayaquez, several juveniles with prior suicide attempts had prescription medication arbitrarily discontinued. At Humacao, a juvenile with a history of self-abuse due to mental problems was in isolation with no plans for psychiatric care pending.

raw pork had been served for lunch at the Industrial School of Mayaguez. At the Juvenile Detention Center in Ponce, a staff person reported that he had seen insects and worms in food to be served to the juveniles. At a number of these institutions, meals are served on the floor or on the bathrooms' shower partition walls.4/ At the time of our visit to the Industrial School of Mayaguez, pestiferous dogs were seen eating from unattended food trays intended for juveniles. These dogs apparently "live" outside the facilities and sleep on discarded mattresses left outside the residential areas. These same mattresses are used for juveniles when needed. Such conditions fail to meet constitutional standards requiring a reasonably safe environment.

At most of the institutions visited, there was a total lack of sanitary precautions by those employees who delivered the food, posing obvious risks for the transmission of foodborne illnesses. Such sanitary precaution deficiencies represent a serious threat to the health of the juveniles.

Bathroom areas throughout all the facilities were likewise unsanitary. Urinals were often found leaking. Water drainage areas were frequently clogged, indicating serious sewage and plumbing problems. At some facilities, soap is not provided and clothes are not washed.5/ Only those youths who are fortunate enough to have family members who provide clean clothes and soap can maintain acceptable levels of hygiene. No supplies are provided to keep cells clean.

The physical structures of the detention facilities also threaten juveniles' safety and compromise their right to be free from unreasonable risks of harm. Juveniles are housed in crowded conditions in cells which open only by the use of an individual key. All facilities lack mechanical locking systems which can lock or unlock all or groups of cells simultaneously. Moreover, there is no intercom system in the buildings. Juveniles are frequently unmonitored for extensive periods of time due to the lack of adequate numbers of staff to make rounds and otherwise supervise the juveniles. Lack of adequate supervision has resulted in harm to juveniles housed in these facilities caused by juvenile-on-juvenile assaults.

4/ Our experts observed such practices at the Industrial School of Mayaguez, the Social Treatment Center of Ponce, the Juvenile Detention Center of San Juan, and the Juvenile Detention Center in Humacao.

5/ Such conditions were observed at the Juvenile Detention Center in Humacao and the Juvenile Detention Center in Hato Rey.

5. Crowding. In several facilities, residents had no beds and were required to sleep on mattresses on the floor for protracted periods of time. Too frequently, because there were insufficient numbers of mattresses, juveniles were forced to sleep on the floor, a condition which is constitutionally intolerable.

6. Abuse, Violence, the Arbitrary Administration of Discipline and the Imposition of Punishment.

a. Abuse by Staff. Our investigation revealed that the Commonwealth does not have an adequate system for the review of alleged incidents of abuse and the excessive use of force at the facilities that we visited. Reports of abuse, brought to our attention by both juveniles and staff, were widespread and particularly notable in Mayaquez and Humacao. A review of incident reports at these facilities confirmed these reports. Specific allegations included that juveniles have been abused by security guards. We received a significant number of allegations that guards have beaten individual juveniles during searches for contraband. The reports suggest that during these searches juveniles are routinely herded into designated areas, forced to lie on the ground, and are struck with night sticks. Very serious allegations were made by juveniles that various juveniles, having been stripped of their clothes and handcuffed, are dragged by the hair by security guards outside the residential areas and beaten.6/ Other allegations received suggest that youth have been improperly maced and assaulted with "stun guns" by security staff.

While our investigatory activities did not extend to investigations of these numerous allegations of the abuse of individual juveniles by individual security guards, we did determine that all of these facilities lack proper mechanisms and procedures to identify possible abuse of juveniles, fully investigate such allegations, make proper findings, and take appropriate action should abuse be found to have occurred. Presently, juveniles lack any internal administrative protection against abuse.

Officials of the Administration of Juvenile Institutions indicated that proper safeguards for reporting of abuse include telephone "hot lines" whereby youth can directly call the central administration with complaints of abuse, and locked boxes where youth can confidentially file written reports of abuse. We found, however, that many of these telephones are inoperable and that juveniles do not have access to the boxes. Both youth and

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6/ In many of the reports corresponding to these reported incidents, the social worker would corroborate injuries to the juveniles.

staff expressed a lack of confidence in this system indicating that responsive action was generally not taken even when complaints reached the attention of appropriate institutional administrators.

In addition, we ascertained that there are no clear, written policies for the use of force, the administration of discipline, or the use of seclusion. The lack of such policies hinders the proper handling of these matters by security staff.

b. Violence Perpetrated by Other Juveniles. Our consultant found, and institutional staff confirmed, that organized youth gangs present the greatest threat of harm to juveniles at all facilities. Gang members often systematically instigate violence as they are transferred throughout the entire juvenile system. Attacks and reprisal assaults are often "ordered" by other gang members once a member of a rival gang is identified. The ability of staff to control gangs and gang related violence has been hampered by inadequate numbers of staff, crowded conditions, lack of proper classification of juveniles, and the absence of training of staff as to how to address violence, potential violence, and other issues in juvenile institutions.

7. Inadequate Out-of-Cell Activities. Juveniles are not afforded opportunities to leave their cell areas for exercise. Because juveniles are further required to eat all meals in their cells, we encountered situations where juveniles do not leave their cells for weeks at a time, ostensibly due to staff shortages. Both staff and youth report that, notwithstanding the presence of basketball and tennis courts and large grassy areas, outdoor activity rarely takes place. During our visits, we rarely observed juveniles partaking of any outdoor activities. Asked to explain the lack of outdoor activity, security staff indicated that the lack of adequate staff and the frequent occurrence of escapes directly affected the time the juveniles were able to leave residential areas. While security is a legitimate concern, staffing and security concerns may not justify, to the extent that we observed at most facilities visited, an ongoing failure to afford juveniles some opportunities of time out-of-cell in which to exercise.