IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF OKLAHOMA

THE UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	
	)	
v.	)	**CIVIL ACTION NO: 06-CV-673-GKF-FHM**
	)	
1. THE STATE OF OKLAHOMA;	)	
2. THE HONORABLE BRAD HENRY, Governor of the State of Oklahoma, in his official capacity only;	)	
3. THE OKLAHOMA OFFICE OF JUVENILE AFFAIRS;	)	
4. ROBERT E. CHRISTIAN, Executive Director of the Oklahoma Office of Juvenile Affairs, in his official capacity only;	)	
5. THE OKLAHOMA BOARD OF JUVENILE AFFAIRS;	)	
6. LONELIA L. SIMMONS, Chairperson of the Oklahoma Board of Juvenile Affairs, in her official capacity only; and	)	
7. JIMMY MARTIN, Superintendent of the L.E. Rader Center, in his official capacity only,	)	
	)	
Defendants.	)	
	)	

UNITED STATES' MOTION FOR PRELIMINARY INJUNCTION

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES: **PAGE**

CASES (continued): **PAGE**

STATUTES:

RULES:

Pursuant to Fed. R. Civ. P. 65, the United States moves the Court for a preliminary injunction based upon the current and ongoing serious harm and risk of serious harm to youth confined at the L.E. Rader Center ("Rader"). Incidents of rape, sexual assault, youth-on-youth violence, excessive force, improper restraint, contraband, attempted suicide, and youth self-harm, are all combining to result in dangerous and life-threatening conditions in the facility.

Harmful and dangerous incidents at Rader continue to occur two years after the United States first brought similar incidents to the State's attention in June 2005. See Letter from R. Alexander Acosta, Assistant Attorney General, Department of Justice, Civil Rights Division, to Governor Brad Henry (June 8, 2005) (United States' "Findings Letter") (Attachment A). Defendants' reactive and piecemeal approach to the dangers, terminating individual staff and disciplining youth for harming other youths, staff, and themselves, has failed to address the ongoing risk of serious harm to youth at the facility. Instead, Defendants continue to expose youth to an ongoing serious risk of harm resulting, in significant part, from the facility's lack of sufficient numbers of appropriately trained direct care staff to adequately supervise youth.

This motion is based entirely on documents produced by Defendants in response to the United States' First Request for Production of Documents ("First Request"). The documents referenced throughout this motion include investigations conducted by the Sand Springs Police Department, by Oklahoma State agencies, and by Rader itself, as well as incident reports prepared by Rader staff.[1]

For the reasons set forth below, the United States respectfully requests an order:

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[1] All of the names in this Motion are pseudonyms to protect the privacy of youth and staff at Rader. A key to the actual names of the youth and staff is attached, under seal, at Attachment B.

(1) granting a preliminary injunction against Defendants' ongoing failure to protect youth from harm resulting from rapes, sexual assaults, youth-on-youth violence, excessive force, improper restraints, contraband, attempted suicides, and youth self-harm; and (2) ordering Defendants to refrain from exposing youths to serious harm resulting from inadequate supervision of youth by insufficient numbers of inappropriately trained staff.

I. BACKGROUND

The United States brought this suit under 42 U.S.C. § 14141 ("Section 14141"), following a multi-year investigation into the conditions at Rader and subsequent unsuccessful efforts to amicably resolve the United States' findings of unconstitutional conditions. The United States seeks injunctive relief to eliminate Defendants' "pattern or practice of conduct" that deprives juveniles at Rader of "rights, privileges, or immunities secured or protected by the Constitution or laws of the United States." 42 U.S.C. § 14141. The United States' amended complaint alleges that Defendants have engaged, and continue to engage, in a pattern or practice of failing to: (1) ensure that youth are adequately protected from harm and from undue risk of harm; (2) implement an adequate system to prevent youth from attempting suicide and engaging in self-harm; (3) provide adequate mental health care to youth; and (4) provide qualified youth with adequate special education and related services.

The United States' multi-year investigation commenced on March 31, 2004, when the Justice Department notified Defendant Henry by letter that it would conduct an investigation of Rader focused on protecting residents from harm. During the pre-litigation investigation, the United States requested documents and access to the facility, staff, and youth. The State produced some of the documents requested, including incident reports, youth grievances,

disciplinary reports, and abuse investigations. Defendants refused the United States' May 2004 request, and repeated subsequent requests, for access to the facility, staff, and youth. Despite Defendants' lack of cooperation, the United States gathered sufficient evidence, based on the pre-litigation documents provided by the State, to issue a 16-page findings letter on June 8, 2005, which detailed how the conditions of confinement violated the constitutional rights of youth.

The United States requested a meeting with Oklahoma officials to try to produce a mutually agreeable resolution to the investigation. The State responded with a letter on July 22, 2005, in which it reported the results of individual investigations into the representative incidents set forth in the United States' Findings Letter, yet failed to propose how the State would prevent such incidents in the future. See Letter from E. Clyde Kirk, Oklahoma Assistant Attorney General, to Bradley J. Schlozman, Acting Assistant Attorney General, Department of Justice, Civil Rights Division (July 22, 2005) (State's "Response Letter") (Attachment C). In its Response Letter, the State also solicited financial aid and technical assistance from the United States. At a September 16, 2005 meeting, the State finally agreed to permit the United States and its consultants access to Rader to review documents and interview staff and youth.

Between November 14 and 17, 2005, the United States and its consultants inspected Rader, which included on-site review of documents, interviews with staff, and interviews of youth confined at Rader. During this tour of Rader, the United States not only confirmed the findings set forth in the United States' Findings Letter, but also found additional ongoing deficiencies regarding Rader's provision of mental health care. The United States conveyed these findings to Defendants during a multi-hour exit briefing with State officials at Rader on November 17, 2005. After the United States unsuccessfully attempted to negotiate with the State

following the inspection, it filed the instant suit on December 15, 2006. On May 4, 2007, the United States amended its complaint with education claims.

On February 7, 2007, the United States served upon Defendants the United States' First Request for Production of Documents ("United States' First Request"). Defendants' first production in response to this request occurred on April 6, 2007, when Defendants produced documents dated through February 1, 2007, maintained by Defendant Oklahoma Office of Juvenile Affairs (OJA). The United States recently received supplemental documents covering incidents occurring through June 2007. A preliminary review of these documents reveals a continued dangerous pattern of youth suffering serious injuries and being exposed to risk of serious injury at Rader, as described below in further detail.

At this stage of discovery, Defendants have already produced documents showing that Defendants have failed and continue to fail to protect youth at Rader from serious injuries and risk of serious injuries from: (1) rape and sexual assaults; (2) youth-on-youth assaults; (3) excessive use of force and inappropriate restraints; (4) youth's possession of dangerous contraband; and (5) suicide and self-harm. The United States seeks a preliminary injunction to prevent harm and to decrease the imminent risk of harm resulting from these incidents.

II. LEGAL STANDARD FOR A PRELIMINARY INJUNCTION

Pursuant to Fed. R. Civ. P. 65, to obtain a preliminary injunction, the United States must prove: (1) irreparable injury unless the injunction issues; (2) that the threatened injury outweighs whatever damage the proposed injunction may cause Defendants; (3) that the injunction would not be adverse to the public interest; and (4) a substantial likelihood of success on the merits. Summum v. Pleasant Grove City, 483 F.3d 1044, 1048 (10th Cir. 2007) (quoting

Schrier v. Univ. of Colorado, 427 F.3d 1253, 1258 (10th Cir. 2005)). When a preliminary injunction alters the status quo, is mandatory, or affords all the relief that the movant could recover at the conclusion of a full trial on the merits, the movant must make "a strong showing both with regard to the likelihood of success on the merits and with regard to the balance of harms." Summum, 483 F.3d 1048-49 (citing O Centro Espirita Beneficiente Uniao Do Vegetal v. Ashcroft, 389 F.3d 973, 975-76 (10th Cir. 2004) (en banc)). "An injunction alters the status quo when it changes the 'last peaceable uncontested status existing between the parties before the dispute developed.'" Summum, 483 F.3d at 1049 (quoting Schrier, 427 F.3d at 1260). An injunction is mandatory if it "affirmatively require[s] the nonmovant to act in a particular way, and . . . place[s] the issuing court in a position where it may have to provide ongoing supervision to assure the nonmovant is abiding by the injunction." Schrier, 427 F.3d at 1261 (quoting O Centro, 389 F.3d at 979).

As detailed below, this Court should enter an order preliminarily enjoining Defendants from continuing to subject the youth at Rader to an imminent risk of irreparable physical harm. Sections III through VII below analyze the four preliminary injunction factors. Section III relies on Defendants' documents[2] as evidence of the likelihood of success on the merits that Defendants systematically continue to fail to protect youths from unconstitutional: Sec. III.A, rapes and sexual assaults; Sec. III.B, youth assaults, excessive force, improper restraints, and contraband; and Sec. III.C, attempted suicides and self-harm. Section IV explains why these unconstitutional conditions are causing imminent and ongoing irreparable harm. Section V

[2] Defendants' documents cited throughout this motion as examples of the ongoing pattern or practice of harm and risk of harm are attached in numerical Bates number order (Attachment D) (under seal because the documents include confidential information).

requests minimal injunctive measures to lower the high rate of these irreparable injuries. Section VI balances the harms, and explains how these severe irreparable injuries heavily outweigh the cost to Defendants of remedying the unsafe conditions. Finally, Section VII shows that the preliminary injunction will serve the public's interest in enforcing these constitutional rights and protecting youths from unsafe conditions.

III. LIKELIHOOD OF SUCCESS ON THE MERITS

A. Defendants Have Failed and Continue to Fail to Protect Youths at Rader from Serious Injuries, and Risk of Serious Injuries, from Sexual Assaults by Other Youths at Rader.

The Fourteenth Amendment gives juveniles taken into State custody right to reasonably safe conditions of confinement. Youngberg v. Romeo, 457 U.S. 307, 324 (1982) (holding that Due Process mandates that State has "the unquestioned duty to provide reasonable safety for all residents and personnel within the institution."); Yvonne L. v. New Mexico Dep't of Human Servs., 959 F.2d 883, 893 (10th Cir. 1992). This right includes a freedom from a substantial risk of sexual assault by staff or other youths. See, e.g., Smith v. Cochran, 339 F.3d 1205, 1212 (10th Cir. 2003) (affirming that an inmate's "constitutional right to be secure in [his] bodily integrity" includes the right to be free from sexual abuse) (quoting Hovater v. Robinson, 1 F.3d 1063, 1068 (10th Cir. 1993)); Hobock v. Grant County, 216 F.3d 1087, No. 99-2194, 2000 WL 807225, at *2 (10th Cir. June 23, 2000) (table) (finding that youths in custody at a juvenile detention facility have a right under the Fourteenth Amendment to be free from physical and sexual assaults by other youths). Thus, the Constitution mandates that the State must provide adequate supervision and monitoring to ensure reasonably safe conditions, including the absence of sexual assaults.

As exemplified below, Defendants' own documents reveal a pattern of rape and sexual assault at Rader. This pattern has continued even after the United States notified Defendants of this problem in 2005. Youth-on-youth sexual assaults often occur in areas lacking adequate supervision, such as the unit bedrooms and bathrooms, and involve serious injuries and risk of serious injuries to youths when aggressors use a common mode of attack - "choking out" the victim until he is unconscious and helpless to the ensuing sexual assault.

Defendants' documents also reveal sexual relationships between Rader staff and youths. Given the staff's position of power over the youths, it is doubtful that these youths can truly consent to sexual relationships with the staff. Regardless, these sexual relationships show a lack of supervision and compromised facility security. See Fisher v. Goord, 981 F. Supp. 140, 175 (W.D.N.Y. 1997) ("Sexual interactions between correction officers and inmates, no matter how voluntary, are totally incompatible with the order and discipline required in a prison setting. Further, the Court is disturbed by the notion that an inmate might feel compelled to perform sexual favors for correction officers in order to be on the officer's "good side." Such *quid pro quo* behavior is inappropriate, despicable and serves no legitimate penological purpose."). For example, these improper relationships introduce contraband when staff bring items for the youths with whom they are involved, such as money, drugs, and cell phones. Defendants' documents illustrate that these items can cause fights and sexual misconduct among youths as well.

1. Youth-on-Youth Sexual Assaults

The following examples show a pattern of incidents of youth-on-youth sexual assaults that, according to Defendants' own documents, have continued to occur at Rader since the United States notified Defendants of this problem in 2005:

- On July 13, 2006, youth Oz Thibault alleged that he was physically and sexually assaulted by four other unidentified youths. Thibault alleged that he was choked from behind when he was in the shower area of his unit. Thibault lost consciousness and when he awoke, he was bleeding from his rectum. Thibault stated that he reported the rape to medical staff on July 14, 2006, and he was sent to the hospital for a rape exam. The rape exam results are not known. Despite Thibault's statements that he was threatened with another assault if he reported the incident, the case was closed without further testing of DNA evidence because Thibault recanted. A report by the Sexual Assault Nurse Examiner, Anna Smith R.N., noted that Thibault had numerous visible abrasions on his penis, head, neck, and elbow, bruises on his arm, and contusions on his shoulders. 1USvOK077552-077570.

- On May 15, 2006, youth Neil Smoot assaulted youth Tomas Benitez in the bathroom. Smoot hit Benitez in the face and threatened him with more physical violence if youth Benitez did not perform oral sex on Smoot. The youths had been permitted to enter the bathroom unsupervised. 1USvOK095015-095020.

- On April 28, 2006, youth Timothy French allegedly physically and sexually assaulted youth Cameron Bell by choking Bell until he passed out and then sexually assaulting him in youth French's room. Staff were unaware that the youths were in the rooms. The youths gained access to the room because the lock was not functioning. 1USvOK094895-094900.

- On Thursday April 27, 2006, youth Darius Foster reported to staff that youth Walker Orwell had threatened to beat Foster up if Foster did not let Orwell put his penis in Foster's rectum. Under this duress, Foster allegedly allowed Orwell to penetrate him with his penis. 1USvOK037158-037159. According to facility documents, youth Foster has mental retardation and an IQ of 55. 1USvOK037160-037161. Rader did not report the alleged rape to police or other authorities until the following Monday, May 1, 2006. 1USvOK077302-077316, 1USvOK037160-037161. As Rader's Superintendent noted, a rape examination could not be completed because more than 72 hours had lapsed since the rape. 1USvOK037160-037161. Foster further reported to the police that Orwell demanded that Foster perform oral sex or Orwell would beat him and that Foster complied and performed oral sex on Orwell. Rader failed to preserve any potential physical evidence, such as Orwell's semen, which Foster stated he spat in a trash can. Sand Springs Police Report 06-006665, 1USvOK037150-037153. Besides the pattern of serious harm to youths resulting from inadequate supervision, this incident illustrates clear deficiencies in staff training regarding appropriate responses to rape and other criminal allegations. Police noted that Defendants' failure to promptly report this incident and to promptly provide the youth with medical attention significantly compromised the criminal case. 1USvOK037150-037153.

- On April 3, 2006, at approximately 8:30 p.m., youth Romeo Keishon entered his room with youths Oz Thibault and Porter Griggs. Keishon had been arguing with the other

two, and they went to the room in order to fight. Upon entering, Thibault allegedy grabbed Keishon around the neck and began choking him until Keison passed out. When Romeo Keishon regained consciousness, his pants and underwear were at his ankles and he felt a wet substance in his anal area. One of the alleged suspects confessed to the Rader Deputy Superintendent that he had choked Keishon to unconsciousness and raped him and that, when Keishon began to regain consciousness, the other suspect choked Keishon into unconsciousness and then also raped Keishon. A medical examination of Romeo Keishon confirmed anal penetration, and Keishon had several scratches and a large bruise on his face and neck. It is unclear how staff on the unit were unaware of the sexual assault, and apparently no report was completed until Keishon told a psychological clinician the following day that he feared for his safety on the unit. 1USvOK077155-077173 and 1USvOK036853-036922.

- On September 10, 2005, youth Dominic Isaiah called youth Tracy Jenner into youth Willis Nevins' room. When Tracy Jenner entered, Dominic Isaiah grabbed Jenner's butt and called him girls' names. Willis Nevins then blocked the entrance so that Jenner could not leave. Tracy Jenner performed oral sex when Isaiah demanded it because Isaiah's criminal record intimidated him. Isaiah also penetrated Jenner's anus. Staff Xandra Atkinson and Emily Gumbel eventually interrupted after seeing Willis Nevins continually looking outside his door every time somebody passed by, but not until after these sexual acts. LER-00379 to 00380, LER-33011 to 33012, LERC000574-000575.

- Sometime in March 2005, the document contains conflicting dates, youth Byron Teacher complained that youth Dominic Isaiah asked "if he could feel on him or the other way around." After Byron Teacher refused, Isaiah anally penetrated Teacher with his penis in the shower. Dominic Isaiah then threatened to hurt Teacher if he did not perform oral sex. Youth Terrence Owens walked in on the oral sex coerced by Isaiah. LER-00256.

2. Unsupervised Sexual Misconduct among Rader Youths

In addition to allowing sexual assaults perpetrated by other youths with violence or threat of assault, staff have left youths unsupervised, permitting them to engage in sexual misconduct with each other. Investigations of such sexual misconduct have been terminated prematurely because investigators deemed the sexual misconduct to be "consensual," despite the uniquely coercive environment of a juvenile correctional facility. For example, in December 2004, youths Armando Cornsilk and Mike Lowell engaged in sexual activity on five to seven occasions, including oral sex, anal sex, and masturbation. The original call to the police was for a possible

rape of a 17-year-old. This allegation was not pursued as a criminal investigation, as the youths allegedly "consented." The police report stated, however, that it is "disturbing that the RADER staff doesn't appear to have a clue as to what the inmates are doing at any particular time. If any crime happened it would be failure to protect by the RADER staff and facility management." LER-00164, LER-32974, LERC000537. Each of the following incidents of sexual misconduct illustrate the unsupervised environment, which enables other acts of violence against youths such as the sexual and physical assaults described in other sections of this motion:

- On February 6, 2007, youth Ben Kane admitted to staff Natasha Lee that he had oral sex with youth Hakeem Masterson on January 19, 2007. At a disciplinary hearing Kane was found guilty of sexual misconduct. There is no indication that any staff was investigated and/or disciplined regarding the supervision failure that allowed two youths to engage in sexual activity on the unit housing sexual offenders. 1USvOK103099-103107.

- Rader staff reported on February 5, 2007, several youths were involved in ongoing sexual relationships manifested during lapses in supervision. Youths Tracy Jenner and Pierce Hall exchanged oral sex. In addition, the youths reported that other youths Carmello Noble, Robert Flick, and Craig Igsby have engaged in oral sex and that youths Ben Kane and Hakeem Masterson have exchanged oral sex. 1USvOK103754-103755.

- Police investigated one of the above incidents reported on February 5, 2007, involving alleged oral sex between youths Tracy Jenner and youth Pierce Hall. Both youths admitted to engaging in oral sex in a bedroom during a shift when youths were unsupervised because staff member Jodie Cooper was sleeping and staff member Thomas Dimple was doing laundry. According to Pierce Hall, the youth waited for the "perfect night" to act because they knew that "some staff check the rooms every few minutes." Sand Springs Police Report 07-001820, 1USvOK038301-038315; 1USvOK103746-103767; USvOK104159-104182.

- On October 14, 2006, youth Tucker Long was allegedly sexually assaulted by youth Wallace Thatcher. Tucker Long made inconsistent statements and recanted his rape allegation. Accordingly, rape examinations were not conducted. The police closed the case as consensual sex between the youths. The validity of the finding of "consensual" sex is questionable, given the predatory and threatening environment at Rader. An internal Investigative Report noted that videos revealed that only one staff member was on duty for the unit on that night, that the staff member left the unit at times, and that bed checks were not completed as documented in the logs. 1USvOK077795-077807.

- On September 19, 2006, Youth Willis Nevins admitted to the police that he offered youth Miguel Gonzalez pornographic material in exchange for touching Nevins' penis. He further admitted that he exposed his penis to youth Gonzalez on September 16, 2006, while the youths from the unit were outside the unit. Finally, youth Willis Nevins wrote that he had asked Miguel Gonzalez to "leave his door unlocked" because Nevins planned to jam the lock on his cell door with tissue and enter Gonzalez's unit at night to have anal and oral intercourse with Gonzalez in exchange for the pornographic material. Willis Nevins stated that he had also attempted to initiate a sexual relationship with Youth Tucker Long in exchange for giving pornographic materials to Long. In a written statement, Gonzalez stated that Willis Nevins had also grabbed him in a sexual manner and that he had never told anyone because he "felt threatened by [Nevins's] size." Sand Springs Police Report 06-014662, 1USvOK037706-037731.

- As reported in August 2006, youths Tracy Jenner, Darnell Lambert, and Ben Kane admitted to ongoing sexual activity with each other in the sex offender unit while staff were not watching. Reportedly, reflective security mirrors were installed to assist monitoring the residents. Regardless, the sexual continued. 1USvOK095477-095481.

- On May 6, 2006, youth Wallace Thatcher and youth Dominic Isaiah engaged in sexual activity in Isaiah's bedroom. Video confirms that Thatcher was in Isaiah's room and another youth, Vincent Dennison, reported sexual activity between Thatcher and Isaiah. Video also confirmed that the assigned staff, Amie Robbins, was completing paperwork and did not look up from the desk to notice Thatcher entering Isaiah's room or other youths going in and out of the bathroom without logging into the bathroom. Neither youth was given a medical examination after the allegation. 1USvOK077343-077353.

3. Sexual Relationships between Rader Staff and Youths

In addition to allowing youth-on-youth sexual assaults and youth sexual activity, Rader staff have themselves engaged in inappropriate sexual relationships with youths. These sexual relationships show a lack of supervision and compromised facility security. The following examples show a pattern of incidents of intimate relationships between Rader staff and youths and among Rader youths that, according to Defendants' documents, continues to occur at Rader even though the United States notified Defendants of this problem in 2005:

- On December 23, 2006, youth Tyrone Green reported to staff Dina Jameson that staff Ariel Gold had performed oral sex on him. This youth stated to the police in early January 2007 that Ariel Gold had performed oral sex on him on at least six occasions. Tyrone Green further stated to police that he had maintained a sexual relationship with

Ariel Gold for the past few months. In addition to the sexual relationship, Green reported that Gold periodically brought him cash and, in December 2006, a cell phone. Other staff became aware of the cell phone and the alleged relationship, but did not report the misconduct. Gold admitted to bringing a cell phone into the facility and allowing the youth to use it. Sand Spring Police Report 07-00180, 1USvOK038219-038225.

- On November 27, 2006, staff Kristin Jarvis wrote a statement to the police stating that, since August 28, 2006, she had maintained a sexual relationship with youth Damien Moser from the sex offender unit. Staff Jarvis stated that the relationship involved kissing on multiple occasions and mutual sexual touching. 1USvOK038065-038066. She also admitted to bringing youth Moser contraband, including money and a cell phone. 1USvOK038072. Moser provided a written statement to The police on November 28, 2006, confirming his "boyfriend, girlfriend type" relationship with staff Jarvis. Damien Moser further stated that he used the money Kristin Jarvis brought him to purchase other contraband in the facility, including pornographic photos depicting sexual acts, and tobacco. Sand Springs Police Report 06-018517, 1USvOK038061-038123. A letter written by staff Jarvis to youth Moser was discovered, which led to Jarvis' forced resignation in December 2006. 1USvOK077855-077868.

- On January 25, 2006, staff Patrice Ericson admitted to The police that she had an intimate relationship with youth Arlen Fuller. Their sexual contact included hugging and kissing. Sand Spring Police Report 06-001477, 1USvOK036562-036568. Staff Ericson admitted to kissing youth Fuller on at least three occasions and hugging him on at least two occasions when they were alone in his room. A letter written by Ericson to youth Fuller expressing her desire to have sex with him was discovered, which led to Ericson's termination on January 27, 2006. 1USvOK076871-076880.

Although staff involved in the above-cited incidents were terminated, asked to resign, and/or criminally charged, this after-the-fact response fails to prevent the unsafe conditions for the youths. Moreover, such a response does nothing to address the systemic failures that allowed these relationships to occur in the first place, and continue to occur for, at least, a twelve-month period after notification of the first incident in January 2006. For example, although individual staff were terminated and/or asked to resign, there was no review of the supervisory and oversight systems at Rader, nor was there a review of the circumstances that allowed for staff to engage in intimate physical contact with youths, on multiple occasions, undetected or unreported.

B. Defendants Have Failed and Continue to Fail to Protect Youths at Rader from Youth-on-Youth Assaults, Excessive Use of Force, and Improper Restraints, Resulting in Serious Injuries. Similarly, Defendants' Failure to Protect Youths from Dangerous Contraband Also Causes Serious Harm and Risk of Serious Harm.

Juveniles taken into custody by the State, like Rader youths, have a Fourteenth Amendment right to reasonably safe conditions of confinement. Youngberg v. Romeo, 457 U.S. 307, 324 (1982) (holding that Due Process mandates that State has "the unquestioned duty to provide reasonable safety for all residents and personnel within the institution."); Yvonne L. v. New Mexico Dep't of Human Servs., 959 F.2d 883, 893-94 (10th Cir. 1992) (holding that youths involuntarily in state custody are "'entitled to more considerate treatment and conditions' than criminals") (quoting Youngberg, 457 U.S. at 321-22). At Rader, however, youths are repeatedly assaulted by other youths. Moreover, youths routinely suffer serious injuries from these assaults requiring significant medical treatment and oftentimes emergency room and hospital visits.

Additionally, Rader staff frequently physically restrain youths, employ force that is disproportionate to the threat posed by youths, and, in a gross departure from professional standards, engage other youths to perform restraints on youths. Although staff legally may employ physical force when youths pose an immediate risk of harm either to themselves or to others, the amount of force used must be the least amount necessary to control the situation and prevent injury to staff and youths. Youngberg, 457 U.S. at 324 (stating that staff may restrain residents of a state rehabilitative facility only to the extent necessary to ensure safety or provide needed training); Yvonne L., 959 F.2d at 893 (applying Youngberg standard to Fourteenth Amendment "failure to protect" claims by foster children in custody of the state); Milonas v. Williams, 691 F.2d 931, 942-43 (10th Cir. 1982) (invalidating use of undue physical force).

As part of reasonably safe conditions, the State must also provide adequate supervision and monitoring to ensure the absence of dangerous contraband that could result in serious injuries to youths at Rader. See Berry v. Muskogee, 900 F.2d 1489, 1498 (10th Cir. 1990) (noting that prison's failure to enforce contraband policy in the face of known and pervasive risks may constitute deliberate indifference to inmate's safety in violation of minimum constitutional standards) (citing Goka v. Bobbitt, 862 F.2d 646, 651-52 (7th Cir. 1988)).

As set forth in the examples below, Defendants' documents reveal that they continually fail to protect youths from physical assaults by other youths, from excessive use of force and improper restraints by Rader staff on youths, and from introduction of dangerous contraband.

1. Youth-on-Youth Assaults

Youths at Rader have suffered serious injuries requiring hospitalization because of rampant youth-on-youth violence occurring at the facility. Injuries include broken jaws, lacerations, black eyes, and contusions. Youths also have been knocked and choked unconscious from assaults by other youths. This violence occurs regularly at the facility, sometimes after staff have been made aware of threats of violence against the victim and the victim is nonetheless later attacked by multiple youths. There are also documented examples of youth-on-youth assaults in which staff allegedly have paid youths in cigarettes, cash, or candy to assault other youths, or in which staff have seen assaults, yet neglected to make any attempt to stop the assaults. The following examples illustrate the pervasive harm and the ongoing threat of serious harm:

- On February 5, 2007, youth Wendell Richards attacked youth Ned Evans, punching him in the face until Evans fell unconscious. When Evans regained consciousness, his left eye was swollen shut, his nose was bleeding, and he felt sick to his stomach. His injuries required treatment at the hospital. The police investigation was closed as "mutual

combat." According to the police , this "mutual combat" spanned at least two days, involved pushing and shoving, and culminated in the above attack, occurring when the youths were unsupervised. Evans reported to police that he felt he had no choice but to fight Richards, because otherwise he would have been attacked by 4 other people at once. Sand Springs Police Department Complaint 07-001833 and 1USvOK038314-038351.

- On January 25, 2007, youth Oliver Nifong attacked youth Sergio Walker, reportedly because a staff member confiscated a lighter from youth Walker that youth Nifong had loaned to Walker. It was the only lighter available on the unit at the time (lighters are contraband at Rader). During the assault, Nifong punched Walker in the face with a closed fist, knocking Walker to the ground. Nifong then kicked and stomped Walker in the face and head. Walker received bruising to his face (including a black eye), neck, back, and chest. 1USvOK038286-038300.

- On December 10, 2006, youth Christopher Copeland allegedly assaulted youth Marc Teborek in the bathroom. Teborek sustained a laceration on his head and was sent to the emergency room, where he received four sutures to close the wound. He also had two black eyes and a laceration on his chin because of the assault. Staff Emily Gumbel stated that she heard a commotion in the bathroom and she tried to enter, but someone was holding the door shut. Teborek exited the bathroom with blood all over him. The police reviewed videotape of the incident, but the video skipped between residents and could not be used as evidence. 1USvOK095979-095982.

- On November 18, 2006, youth Pierce Hall was told by two other youths that they were going to "beat him in" as a member of their gang. Both then beat Hall in the face and head with closed fists, knocking him to the ground. The assault occurred out of the view of the unit's security cameras. Hall sustained a black eye and multiple knots on his head. When staff found Pierce Hall after the attack, Hall stated that he had fallen and had hit his head. Hall later confessed that he was afraid to report the incident for fear of reprisals. Sand Springs Police Department Complaint 06-018209, 1USvOK038044-038060.

- On October 16, 2006, youth Sean Cregg assaulted youth Ayashe Huritt, lacerating and breaking Huritt's nose. While on the floor, Huritt was unresponsive to the first responder, staff person Evan Hastert. Huritt was taken to St. John Hospital where he received stitches and was diagnosed with a broken nose. According to Huritt, earlier in the day, Sean Cregg had shoved an object into Huritt's ear, knowing that Huritt is partially deaf. Sand Springs Police Department Complaint 06-016278, 1USvOK037941-037961.

- On September 24, 2006, youth Patton Paulwood told youth Oz Thibault to come to his room. Thibault entered Paulwood's room, and Paulwood punched him in the face and head. Thibault was knocked to the floor and could not move. Then Paulwood jumped in the air and stomped on Thibault's head with his foot at least twice. At that point, Thibault lost consciousness. Police collected Paulwood's shoes, which had blood on

them. Thibault required stitches in his head. Sand Springs Police Report 06-015132, 1USvOK037815-037846. A few days after this fight, youth Peter Donnelly stated to Rader staff that Thibault was assaulted in retaliation for an assault by Thibault on youth Shawn Unger earlier that same day. Allegedly, as stated by multiple youths, Thibault assaulted Unger because Rader security staff put a "hit" on Unger in retaliation for Unger alleging that he had been slapped in his bedroom by security staff Kaleolani Oates. This "hit" on Unger involved Rader security staff giving Thibault a pack of cigarettes to assault Unger. Thibault also claimed that staff had a "hit" on Unger, but that he had not attacked Unger. Following the assault by Thibault on Unger, staff person Pavel Ivanko reportedly noticed that Unger was crying and that there was blood on Unger's toilet and hands, but staff Ivanko failed to make a report. 1USvOK037844-037845.

- On September 24, 2006, youth Yancy Abrams assaulted youth Oz Thibault in the dayroom while Thibault was watching television. Video confirmed that Abrams punched Thibault in the jaw. Minutes before this incident, Thibault was assaulted by another unidentified youth. Staff Uma Winter and Leah Oliphant were on the unit at the time, but neither staff was aware of the assaults when they happened. The police investigation stated that, contrary to a directive from Rader Superintendent Martin, residents' doors were not locked and residents were allowed to move freely and unsupervised into each other's rooms. Also, despite a group of youths congregating in one area, staff did not respond. 1USvOK095777-095781. Incidentally, staff Uma Winter was involved in another incident with youth Yancy Abrams on October 7, 2006. Abrams alleged that staff Winter threatened to stab him in the eye with her pen. Another staff, Olivia O'Toole, confirmed that Staff Winter threatened several times that she was going to "take Abrams out." Staff O'Toole had to call security to have staff Winter removed from the unit "so that things would calm down." Staff Winter resigned. Misconduct was confirmed as to staff Winter. 1USvOK095826-095829.

- On July 11, 2006, youth Lindsay Leland was discovered lying face down on his right cheek, unconscious, and with a puddle of blood coming from his mouth. No further details regarding the cause of Leland's injuries appeared in Defendants' documents. Security and medical staff were apparently called, but the facility report does not indicate how Leland was so seriously injured or if it was investigated. 1USvOK164394-164409.

- On June 4, 2006, youth Rory Paloma's linens and pillow were contaminated by human feces, but it is not clear who did it. In a facility multipurpose report relating to this incident, staff Rajon Jordan expressed her concern that if Rader does not move Paloma off of the unit, he will continue to be seriously hurt by the other youths. She stated that Paloma has suffered a broken finger, a broken nose, and bruised arms and legs. 1USvOK163383-163388.

- On April 29, 2006, youth Timothy French called out to youth Cameron Bell to come to his room. When youth Bell entered, French put his arms around Bell's neck and choked him until he lost consciousness. When Cameron Bell regained consciousness, he was on

his stomach and French was on top of him. Sand Springs Police Report 06-006633, 1USvOK037123-037149. In a written statement provided to staff at Rader, Bell stated that, prior to this attack, French was trying to get Bell to fight him but that Bell had refused. 1USvOK037126. Cameron Bell continued to be afraid that Timothy French or one of French's acquaintances was going to choke him to unconsciousness again and sexually assault him while unconscious because Bell refused to fight. 1USvOK037126. Apparently believing that he had no other options, Bell wrote in his statement that Rader staff should let him fight French instead of facing the alternative of being choked into unconsciousness and sexually assaulted. 1USvOK037126. Unit rosters for the two weeks following the choking incident indicate that Rader failed to separate Bell and French. 1USvOK002565 (unit roster for May 1, 2006); 1USvOK002579 (unit roster for May 8, 2006); and 1USvOK002591 (unit roster for May 12, 2006) (all showing youth Bell and French remaining together on the same unit).

- On April 28, 2006, youth Hiram Ottowa entered his bedroom at approximately 9:35 a.m. and found that his room had been torn up, and several other youths were standing nearby. As he started to clean the room, an unknown youth came up behind him and started to choke him. As he struggled to get free, he lost consciousness. Another youth kicked him in the head as he lay on the floor, and this blow "jarred him awake." A staff person arrived, finding Ottowa unresponsive on his bedroom floor. Ottowa was then transported to the emergency room, where he received three stitches between his eyes. Sand Springs Police Report 06-006642, 1USvOK037172-037183.

- On April 22, 2006, youth Vernon Cole suffered lacerations requiring stitches on his head while he was in the unit bathroom. Youth Cole reported that he slipped to one staff member, and told another that he was injured while "horse playing in the shower." Youth Lawrence King received a major rule violation for assaulting another youth due to this incident. Video confirmed that Cole entered the bathroom without staff supervision when Lawrence King was already in the bathroom. 1USvOK094845-094850.

- On April 1, 2006, youths from one of the Rader housing units were lining up in the dayroom of the unit to go to dinner, when youth Sean Cregg put his arm around youth Tracy Jenner's neck and pulled him down a hallway and out of sight of the staff and other youths in the dayroom. Tracy Jenner stated to police that he lost consciousness. Staff reported that by the time they realized that Cregg was choking Jenner, Jenner's face had turned purple and his eyes were rolling into the back of his head. In a report, staff who pulled Cregg away from Tracy Jenner noted in capital letters that youth Cregg has a "history of choking out peers." 1USvOK036844-036846. Despite Sean Cregg's attack on Jenner, the youths were not separated and just over an hour later, when the youths had returned to the unit from dinner, Sean Cregg ran into Jenner's room and beat him in the face and head. Only at that point was Cregg removed from the unit. Sand Springs Police Report 06-005201, 1USvOK036842-036852. Cregg threatened that he would continue beating youths until he was moved off the unit. 1USvOK094713-094718; 1USvOK079089-079098; 1USvOK109011-109020; and 1USvOK160858-160864.

- On February 28, 2006, youth Sammy Ackland informed staff that other youths informed him that he was going to get "beat down." Staff's response was to change Ackland's bedroom to a room near the staff desk in a single youth per bedroom unit. During the evening showers, consistent with the earlier warning given to Ackland and reported to staff, four youths attacked Ackland in the showers, with one youth holding Ackland's hands down, one youth kicking Ackland in the ribs and back, and the other two youths punching him in the face and upper body. Ackland was taken to the hospital emergency room. Ackland informed police that the assault had likely occurred as retaliation because he had reported that a youth had stolen cigarettes (contraband at Rader) from another youth. Sand Springs Police Report 06-003558, 1USvOK036805-036817.

- On February 24, 2006, known rival gang members, youth Tyrone Green and youth Greg Mercury, were arguing over a basketball game while supervised by staff member Brenda Lumley. At some point following the argument, Mercury hit Green in the jaw, breaking Green's jaw and requiring Green's hospitalization. 1USvOK094484-094489.

- On February 11, 2006, youth DeShawn Anderson was sent to the emergency room for internal bleeding and he was given a blood transfusion of four pints of blood. Anderson was reportedly jumped, kicked, and choked by other youths approximately a week prior to his emergency room treatment. Before he went to the hospital, Anderson complained of dizziness, vomiting, and nausea, rib and back pain, and that he had not urinated for a day and a half. Anderson alleged that staff failed to take his complaints seriously, instead accusing him of faking his illness. Anderson was eventually sent to the emergency room after his pulse became elevated and his blood pressure dropped. 1USvOK076931-076939.

- On February 3, 2006, youth Paul Barry was "choked out" by youth Elmer Banks until he became unconscious. Elmer Banks stated that this is an ongoing "game" that youths have at Rader. This occurred in the office of staff Margie Ellington, who was present and on the phone with another staff member. There was no medical report. Staff Ellington was orally counseled for not having the youth checked by medical after the incident. However, she was not disciplined for lack of supervision. 1USvOK094407-094410.

- On January 3, 2005, youth Aaron Ziegler attacked youth Ted East with a broom. Youth Mitchell Kelvin tried to stop the fight. Youth Axel Estes entered the room and joined the fight, punching East in the face. The staff broke up the fight but Ted East suffered a broken nose that required a pin to realign. East's neck required rehabilitative exercises, and he suffered defensive wounds on his hands. One week after this serious altercation, Aaron Ziegler and East were still housed together in the same unit. Ziegler came up behind Ted East and squeezed East's neck until East passed out. According to East, he and Ziegler are members of rival gangs. Despite the rival gang membership, and the first serious assault, Rader failed to separate these youths. LER-00148 and LER-00162.

See also 1USvOK036284-036314 (youth knocked unconscious); LER-00359 (fight); LER-00324 (eye injury and split lip).

Even when Rader has a policy intended to prevent youths from assaulting other youths in unsupervised areas such as bathrooms, the policy is not adequately implemented, if at all. The following examples show that Rader staff's failure to follow policies results in harm and an imminent risk of physical harm to youths:

- On February 28, 2006, youth Sammy Ackland was assaulted by youth Oz Thibault, youth Martell Howry, and youth Marcell Yardley in the bathroom. Ackland suffered a golf ball size bruise on his forehead and a bruise near his right eye. He was sent to the emergency room. Sammy Ackland had notified staff Randy Gomez earlier that day that he was afraid of being assaulted. Staff Henry Iverson observed Thibault and Howry entering the bathroom and, instead of following the youths and/or redirecting them away from the bathroom, he proceeded to write disciplinary documents for the two youths. Ackland was assaulted while staff filled out the documents. 1USvOK076954-076973.

- On November 14, 2005, youth Tyrese Kuhn suffered a broken jaw when he was in the bathroom. It was rumored that youth Lawrence King assaulted him, although Kuhn denied this and claimed not to know what happened. According to policy, multiple youths are not allowed in the bathrooms at the same time. Bathroom log sheets could not be located and the video camera monitoring the bathroom area and entry was not functioning. Staff Brian Richardson, was disciplined for failing to provide Tyrese Kuhn with immediate medical care for his jaw, when medical care was delayed for thirty minutes. Kuhn was not sent to the hospital for approximately three hours. Staff supervising the unit during the incident were not disciplined. 1USvOK076769-076784.

Rader has failed to implement systemic corrective actions following incidents involving serious harm to youths to prevent similar harm to youths in the future. For example, on February 5, 2006, youth Travis Hawley and youth Cameron Bell were involved in a physical altercation in Hawley's bedroom. Bell suffered a broken nose. An investigation found that youths were allowed to go unsupervised into each other's rooms. In response to the investigation, on May 10, 2006, Rader indicated that the doors to youths' bedrooms were kept locked and only unlocked for appropriate youths to enter at appropriate times. 1USvOK076890-076892. Despite

this, the following assaults occurred in youths' bedrooms after this alleged policy as youths continued to enter bedrooms to inflict serious harm on their peers:

- On March 4, 2006, youths Hamilton Pitt and Brett Wynn were involved in an altercation in Wynn's bedroom. Hamilton Pitt suffered a broken nose. Other youths restrained Wynn before staff arrived. 1USvOK076993-076999.

- On March 31, 2006, youth Curtis Jackson entered youth Ricky Dawson's room, where youth Tindall Stevens was braiding Dawson's hair. Curtis Jackson verbally assaulted Stevens and then left the room. Jackson returned wearing gloves and punched Tindall Stevens in the face. The two exchanged blows, and Curtis Jackson punched Stevens in the face a second time, with enough force to knock out two of Stevens' teeth. Stevens stated his belief to the police that Jackson had concealed a hard object in his hand on the second punch. There is no indication that staff made any effort to intervene, either after the verbal assault or before Curtis Jackson returned wearing gloves, or after Jackson threw the initial punch. Police file photographs illustrate how two of Stevens' teeth were knocked out at the root. 1USvOK077135-0771154, Sand Springs Police Report 06-005181, 1USvOK036833-036841.

- On May 15, 2006, youth Lawrence King attacked youth Marcos Santiago in Santiago's bedroom. During the assault, King choked Santiago until he lost consciousness. Upon regaining consciousness, Santiago's roommate, a witness to the attack, informed Santiago that King had kicked Santiago the head while Santiago was laying on the floor unconscious. It is unclear where staff were at the time of the assault. Following the assault, Marcos Santiago complained of a severe headache, so he was taken to the hospital, where he was diagnosed with a concussion. 1USvOK077373-077405, Sand Springs Police Report 06-007617, 1USvOK037306-037311.

- On June 25, 2006, youth Nelson Ramirez assaulted youth Rich Eula in his bedroom. Ramirez was waiting for Eula in Eula's bedroom and Ramirez hit Eula several times in the face. Rich Eula was sent to the emergency room, where it was confirmed that he had sustained a broken nose from the assault. 1USvOK095366-095371.

- On August 12, 2006, youth Sean Cregg was assaulted in his bedroom by several unidentified youths. Cregg refused to provide the identity of his attackers and stated that he did not yell because one of his attackers was choking him. Cregg was removed from the unit after he informed staff that he had been attacked. He was also then checked by a nurse, who noted that he had a goose egg bruise on top of his head. At some point after the assault, security was called to Sean Cregg's room because he was suicidal. Video confirmed that, at the time of the attack, youths were allowed to enter into each other's rooms freely and unsupervised. Sean Cregg's room is approximately five feet from staff Randy Gomez's desk, and video confirms that staff Gomez was sitting at his desk while youths entered each other's rooms. As a result of the attack on Cregg, staff Gomez

received a written reprimand and a "Corrective Action Plan." 1USvOK095541-095545.

- On August 24, 2006, youth Tomas Benitez was allegedly assaulted in his bedroom by youth Christopher Copeland. Benitez sustained a laceration under his eye and a black eye. During the incident, staff Ray Ahmed was on the unit but was in his office speaking with other youths. Video confirms that youths were left in the dayroom unsupervised by staff Ahmed. 1USvOK095494-095499.

At the time of all the above assaults, and contrary to the newly-promulgated policy, youths could move freely and unsupervised into each other's rooms.

2. Excessive Use of Force and Improper Restraints of Youths

The following examples document the widespread improper and excessive use of force by Rader staff when restraining youths. These improper restraints pose a significant imminent risk of physical harm to the youths:

- On September 28, 2006, staff member Brad Nolan allegedly improperly and dangerously restrained youth Pedro Fernandez. Fernandez claims that Nolan picked him up and threw him to the ground, elbowing Fernandez in the back of the head three times. Staff member Pavel Ivanko was restraining another youth nearby, and claimed that he did not witness exactly what happened. Ivanko did admit to hearing a loud "smack" that caught his attention. When Ivanko looked over, Brad Nolan had Pedro Fernandez on the ground in an unapproved restraint: Nolan's forearm was across the back of Fernandez's neck. Fernandez suffered abrasions on his forehead. 1USvOK120668-120674.

- On August 18, 2006, staff Raleigh Nork allegedly physically assaulted youth Arthur Yu. Staff Nork improperly and dangerously restrained Arthur Yu when he laid on top of youth Yu, causing him difficulty in breathing and eventually causing him to go into a seizure. Yu was sent to the emergency room. 1USvOK077684-077685.

- On July 22, 2006, as youth William Potter attempted to exit his unit in response to a call for him to obtain his medication, security officer Harvey Hixon pushed him against the wall and told him to stay inside. William Potter stated that he had been called for his medication and, after he turned to leave, officer Hixon pushed him against the wall again. Another security officer intervened, but after Potter obtained his medication Hixon struck Potter in the chest, grabbed him by the throat, and pinched his nipple area. When youth Patrick Culver attempted to help youth Potter, Hixon punched Culver twice and then choked him. 1USvOK120553-120559, and 1USvOK120567-120575. An examination of youth Culver revealed red marks on both sides of his neck and on his chest. 1USvOK037786-037787; Sand Springs Police Report 06-011438/06-011439,

1USvOK037542-037550; and 1USvOK037542-037550. Youth Potter sustained red hand print marks on his neck and redness to his nipple area. This incident occurred outside of video camera range. Two other staff and two other youths confirmed the excessive use of force. Staff Hixon was terminated on July 24, 2006. 1USvOK120548-120555.

- On March 15, 2006, staff Fred Upton and staff Bryant Velazquez restrained youth Joakim Edison and moved him to the crisis unit. Edison alleges that he lost consciousness during the first restraint when Fred Upton held him by the neck. Edison also maintains that he sustained injuries to his eye and elbow during a second restraint. Upton and Velazquez denied that Edison lost consciousness or that there was a second restraint at all. The video cameras could not provide any information because the restraint occurred in areas out of view. 1USvOK077013-077032.

- On January 26, 2006, youth Greg Mercury was restrained in a standing wrap followed by a blend takedown and three-person relax prone restraint.[3] Youth Mercury was restrained for approximately one hour in a dangerous prone restraint for "counseling and de-escalation." 1USvOK130106-130107.

Beyond the illegal uses of force and dangerous restraints employed Rader staff, on numerous occasions, staff have instructed or permitted youths to restrain other youths. Restraints performed by youths constitute a gross and dangerous departure from professional standards. Youth-on-youth restraints at Rader have resulted in severe injuries or risk of severe injuries to both the youth performing the restraint and the youth being restrained:

- On October 30, 2006, staff Barbara Madison instructed youth Corey Marshall to "take down" youth Colin Lopez. Marshall sprained his shoulder. 1USvOK077829-077830.

- On August 13, 2006, multiple youths participated in the restraint of two youths who had been fighting, youths Delonte Hart and Everett Chapman. Youths Malik Fender, Greg Mercury, and Terrence Owens admitted to participating in the restraint. Police stated that video confirmed "residents running all over the place" and incident reports confirmed that "things got completely out of control." 1USvOK095534-095539.

- On October 16, 2005, youth Lawrence King aided in restraining youth Stefan Young after Young threw a VCR and several tapes against a wall. During this youth-on-youth restraint, Stefan Young bit Lawrence King several times. LER-00413.

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[3] The facility uses a "blend takedown" to physically take a youth down to the floor and a three-person "relax" prone restraint to hold the youth face-down on the floor until the staff involved believe that the youth is calm and ready to be released.

3. Dangerous Contraband

Numerous items of contraband, including drugs, are entering the facility. Between December 28, 2006, and January 3, 2007, Rader administered drug tests revealed at least seven youths testing positive for marijuana, and another youth testing positive for methamphetamines. 1USvOK103488-103500 and 1USvOK104013-104023. Many youths have histories of substance abuse, and they are readily able to obtain various types of drugs and other chemicals to get "high" while at Rader. The following examples show that easy access to such contraband is not abating:

- On January 13, 2007, youth Ryan Hooper tested positive for methamphetamines. 1USvOK129120-129129.

- On May 17, 2006, at least three youths from a housing unit – Lincoln Tinsley, Zach Sizemore, and William Potter– tested positive for THC, the main psychoactive substance in marijuana. In addition, staff reported that youths on that unit had been "acting high." 1USvOK095073-095075.

- On April 28, 2006, an empty bottle of Everclear liquor was found in a unit trash can. Prior to its discovery, youths on the unit had been "out of control" and "glassy eyed." Staff on the unit alleged that staff April Brewer had brought the liquor inside Rader and gave it to the youths. Staff Brewer was terminated on May 8, 2006, for bringing cigarettes into Rader. 1USvOK120784-120809.

- On January 15, 2006, a search of a housing unit was conducted after youth Nick DeMarco and youth Ralph Cicilline were discovered in a smoke filled bathroom. The search recovered various items throughout the unit and in multiple youths' rooms and the bathroom, including various colored pills; three razors; three socks with crushed soap; and a rolled up piece of paper with one end burned. Although no tobacco was recovered, staff noted their belief that the smoke came from an "exposed light" that was likely used to light the cigarettes. 1USvOK115178-115191 and 1USvOK157294-157305.

- On October 25, 2005, seven youths on a housing unit tested positive for THC. Six more refused to take the test, or submitted a sample that had been tampered with. LER-18450 to 18454.

- On October 16, 2005, youth Arlen Fuller obtained eight pills of prescription medication.

Fuller tested positive for amphetamines and methadone. Documentation indicated that the medical clinic at Rader could not identify the medication as any type of medication kept at Rader. LER-18624 to 18632.

Many youths have also been discovered with homemade weapons or shanks. Because many youths fear assaults from other youths, they reported that they must protect themselves with homemade weapons:

- On September 21, 2006, youth Greg Mercury told staff Tammy Iglesias that youth Marc Teborek had threatened him with a shank. The shank was a toothbrush with a sharpened end, and it was discovered in the trash can. Youth Vernon Cole also reported to staff Glenda Sands that Teborek threatened to shank him. 1USvOK124727-124733.

- On August 6, 2006, youth Marc Teborek had two metal shanks that he had made from breaking his eyeglasses. He had removed the plastic surrounding the metal ear pieces of the eyeglasses, exposing the sharp metal pieces. 1USvOK122761-122763.

- On April 25, 2006, youth Oz Thibault alleged that he was jumped by three other youths: Timothy French, Martell Howry, and Stuart Tilley. He also told staff that, for his protection, he had hidden a shank in his room. He then retrieved a "long piece of pointed metal" from his clothing shelf and provided it to staff. 1USvOK161751-161753.

- On April 25, 2006, youth Deangelo Everett possessed two pieces of his eyeglasses that were sharpened into a weapon. 1USvOK115290-115295 and 1USvOK161780-161782.

- On February 12, 2006, youth Jefferson Springfield was discovered with a shank, a sharpened end of a fork or a spoon, in his room. 1USvOK158655-158657.

- On October 22, 2005, a shank made out of the sharpened end of plastic silverware was confiscated from youth Eric Fletcher's room. LER-14483 to 14487.

C. Defendants Have Failed and Continue to Fail to Protect Youths at Rader from Serious Harm and Risk of Serious Harm Resulting from Youths Attempting Suicide and Harming Themselves.

Defendants have failed to ensure that youths receive adequate mental health treatment and suicide prevention measures, including adequate supervision in hazard-free environments and, as a result, Defendants have exposed youths at Rader to serious harm and serious risk of harm from self-injury. The Constitution requires that confined juveniles receive adequate mental

health treatment and suicide prevention measures. See Barrie v. Grand County, 119 F.3d 862, 867 (10th Cir. 1997) (applying the Eighth Amendment Estelle v. Gamble, 429 U.S. 97 (1976), standard for medical care in prisons to Fourteenth Amendment claim regarding inadequate suicide prevention in pretrial detention facility); A.M. v. Luzerne County Juvenile Det. Ctr., 372 F.3d 572, 580, 584-85 (3d Cir. 2004) (holding that juvenile detention facility's lack of policies to address mental health of residents gives rise to a claim under the Due Process Clause); Hott v. Hennepin County, 260 F.3d 901, 905 (8th Cir. 2001) (inadequate suicide prevention program equivalent to inadequate medical care). For juvenile offenders, adequate mental health care includes individualized treatment and rehabilitation based on a youth's strengths and needs. See Nelson v. Heyne, 491 F.2d 352, 358-60 (7th Cir. 1974) (holding that youths in juvenile detention facility have a constitutional right to rehabilitative treatment that includes individualized care).

Defendants have failed to ensure that youths receive adequate mental health treatment and suicide prevention measures, including adequate supervision in hazard-free environments. As a result, Defendants have exposed youths to serious harm and serious risk of harm from self-injury at Rader. In many incidents, Defendants' documents also indicate that, in a gross departure from professional mental health care standards, mentally ill youths have been punished for harming themselves. Moreover, Defendants' documents do not provide any indication that they were referred to or seen by a mental health clinician, which, unlike punishment, is the appropriate response. The following incidents demonstrate a pattern of such violations:

- On January 23, 2007, youth Ryan Hooper, who has a history of self-harming behavior as described below, obtained a ruler from the staff's desk cut his arm in his bedroom. Youth Hooper was sent to the emergency room for medical treatment. 1USvOK077905.

- On January 13, 2007, the medical area was left unlocked during pill call. Nurse Crystal Foley had left her bottle of blood pressure medicine containing approximately 40 pills on

the desk in the medical area. Six hours later, the pills were noticed missing. A search recovered 15 pills from youth Ryan Hooper's room. Youth Hooper was taken to the hospital, and he tested positive for methamphetamines. 1USvOK129120-129129.

- On November 6, 2006, youth Verlin Boxer was on medium suicide watch when he broke a mechanical pencil and swallowed it. Medium suicide watch requires line-of-sight observation, but the unit log stated that he was on mild watch. Boxer had made threats earlier that day that he would find a way to get on severe suicide watch, but his suicide status was unchanged when he swallowed the pencil. Boxer had surgery to recover the pencil, which also recovered 23 staples and a key that he had obtained from a sleeping hospital security guard. An internal investigation found that staff had "sufficiently supervised" him and given adequate medical care. 1USvOK120694-120703.

- On October 27, 2006, youth Sean Cregg drank two full caps of cleaning fluid. Earlier that day Cregg reported to staff that he was going to do something to get moved to the Crisis Unit. Cregg was sent to the hospital and treated. 1USvOK077813-077814.

- On October 24, 2006, youth Romeo Keishon told staff Manny Wilson that he did not want to go back to his unit because of threats of physical assault from other unit youths. He stated that he would continue to harm himself if he had to go back to the unit. Keishon was placed in solitary confinement for one hour and fifteen minutes, and then sent back to the crisis unit. At the crisis unit a nurse treated three self-inflicted wounds: two scratches on his wrists, one that was 2 inches long and the other 1.5 inches long, and a bite mark on the back of his hand. Both scratches were shallow. When the nurse came to check his scratches, youth Keishon took the antibiotic ointment tube and ate approximately three inches of ointment. He was placed on medium suicide watch. After the incident, he continued to make suicidal comments and asked youth Verlin Boxer, "what is the easiest way to kill myself? I am tired of my fucking life." Keishon was investigated for the "offense of attempting to harm himself." 1USvOK102105-102118.

- On October 5, 2006, youth Caleb Kingfisher attempted to commit suicide by making a rope from his bed sheet and tying it around his neck. At the time of the incident, Kingfisher was in the crisis unit on "normal fifteen minute watch." Staff Orenthal Prince heard choking noises coming from youth Kingfisher's room. Kingfisher vomited shortly after the attempt. 1USvOK095849-095853.

- On September 14, 2006, youth Verlin Boxer was on suicide watch when he cut his neck with a piece of a calculator. 1USvOK124412-124420. Another youth, Christian Graham, had taken the calculator from Rachelle Obinakeze's classroom and given it to Boxer. 1USvOK095642-095645. A pencil, and pieces of tile, metal, pointed glass, and a broken calculator were also recovered from Boxer that same day. 1USvOK124412-124420.

- On July 30, 2006, youths Nick DeMarco and Delonte Hart were alone in their unit

dayroom. They removed a large roll of toilet paper from an unlocked supply closet. They had made a four foot braided rope that youth DeMarco said he was going to use to kill himself before staff came into the room and confiscated the rope. DeMarco was disciplined for his self-injurious behavior. 1USvOK115235-115241.

- On June 28, 2006, youth Ivan Velleques, while on "medium suicide watch," went into the bathroom unsupervised and used a broken piece of glass to cut his wrist. Velleques stated that he was attempting suicide. Velleques went to the emergency room for the three-inch laceration and sterile strips were used to close the laceration. 1USvOK095391-095395.

- On May 1, 2006, youth Timothy French attempted suicide by tying one leg of his sweat pants around his neck and the other leg around a bar on the ceiling. Another youth found French. French was allowed to enter his room unsupervised, and, contrary to Rader's ratio policy, there was only one staff for 12 youths on the unit. 1USvOK077318-077327.

- On April 26, 2006, youth Verlin Boxer wished to remove stitches from his toe. When the medical staff refused and called for mittens so that he could not pull them out by hand, he began to bite the stitches out. Security responded with the mittens and stopped Boxer. Boxer was charged with self-mutilation and interfering with unit operations and punished by being dropped in the Rader level system and assigned to early bedtime for one week. 1USvOK114212-114220.

- On April 24, 2006, youth Steven Vincent was supposed to be on one-to-one supervision when he took screws out of the wall. One report states that the youth swallowed three screws, but in another he claims he did not. Staff Stan Donaldson denied that he was aware that Steven Vincent was on any suicide precautions at the time. Records, however, confirm that Vincent was on suicide watch. An internal investigation found that "these allegations do not rise to the level of misconduct." 1USvOK094858-094863.

- On April 7, 2006, youth Verlin Boxer started twisting a blanket around, said he was going to hang himself, and put the blanket around his neck. Boxer was disciplined for his behavior. 1USvOK114166-114173; 1USvOK160902-160905.

- On March 9, 2006, youth Verlin Boxer wrote "fuck you" in his own blood on the wall. He had reopened an old wound. Boxer was placed on suicide precautions and was disciplined for his behavior. 1USvOK114147-114153.

- On March 8, 2006, youth Matt Nocioni told staff Leo Moskowitz that if he had a gun he would kill himself. He was placed in the crisis unit for de-escalation but not suicide watch, despite his statements to staff Moskowitz. In the crisis unit, he obtained a staple on the bathroom floor, which he was allowed to enter unsupervised. Nocioni inserted the staple into his hand. Medical saw him, but he was not scheduled to see the doctor to have it removed until two days later on March 10, 2006. Youth Nocioni removed the staple

himself on March 9, 2006. An internal investigation found that there was insufficient evidence to prove staff neglect. 1USvOK077000-077012.

- On February 24, 2006, youth Verlin Boxer put a piece of broom straw into his arm through an opening from an older injury. Boxer was disciplined for this behavior. 1USvOK114142-114146.

- On January 28, 2006, youth Verlin Boxer was observed with blood on his t-shirt and his towel. When asked about the blood, he stated that it came from his toe. Eventually, he was asked to lift up his t-shirt and staff observed number of cuts that were bleeding on his stomach. Boxer stated that he had inflicted the scratches with a razor that he flushed down the toilet. A search was conducted and he was disciplined for his self-harming behavior. 1USvOK114103-114113.

- On January 26, 2006, youth Sean Cregg offered to give pills he had hidden to staff. He led staff into the bathroom, but when staff entered he was putting water in his mouth. Another youth was in the bathroom at the time, and reported that Cregg swallowed at least five pills. Just before this incident, youth Cregg and youth Kalon Morris admitted that they received pills from youth Ryan Hooper. Hooper admitted that he had cheeked his pills. 1USvOK109282-109291; 1USvOK109643-109650.

- On January 2, 2006, youth Verlin Boxer was eating breakfast when he broke the spoon and swallowed a piece of it. Boxer was placed on suicide watch and prohibited from using utensils. Boxer was disciplined for this behavior. 1USvOK114062-114066.

In a series of troubling incidents of serious self-harming by three youths, Rader staff failed to take basic measures to provide adequate supervision to prevent the youths from cutting themselves to the point where hospitalization and stitches were required, failed to fix broken tiles that the youths repeatedly used to seriously harm themselves, and failed to prevent the youths from entering the area with broken tiles unsupervised. This series of events occurred as follows:

- On May 4, 2006, youth Ryan Hooper self-mutilated with pieces of bathroom tile, requiring a trip to the emergency room. Because of this, Hooper was punished with four days of early bedtime and four days of extra detail. 1USvOK112308-112314.

- Eleven days after youth Ryan Hooper mutilated himself with a broken bathroom tile, on May 15, 2006, Hooper again self-mutilated with pieces of bathroom tile, again requiring a trip to the emergency room. Preventive measures, such as repairing the bathroom, apparently were not taken. Ryan Hooper was again punished for his self-harming behavior. 1USvOK112264-112270 and 1USvOK112308-112314.

- Astoundingly, on May 16, 2006, at 10:05 p.m., approximately an hour and 20 minutes after youth Verlin Boxer had mutilated himself with broken bathroom tiles (see write-up below), youth Ryan Hooper was on the Mental Health Stabilization Unit on suicide watch when he went into the bathroom unsupervised and emerged with a bleeding arm. He initially reported that he had cut himself with a piece of broken bathroom tile, but he later reported that he had accidentally opened an old wound. He sustained two cuts to his left arm and the one was approximately three inches long and 1/4 inch deep. He was taken to the emergency room again and the lacerations were closed with medical glue. It is not a surprise that after being disciplined twice in the previous two weeks for cutting himself, Ryan Hooper reported that this was an accident. 1USvOK077437-077442.

- On May 6, 2006, youth Matt Nocioni was on suicide watch when he cut his wrists with a piece of tile while he was in the bathroom unsupervised. Youth Nocioni stated that he received the tile from youth Ryan Hooper. 1USvOK095028-095033 and 1USvOK112287-112293.

- On May 8, 2006, youth Verlin Boxer was in isolation in the crisis unit, when he was observed bleeding from his left hand. When staff requested him to open up his hand, he resisted but then eventually opened his hand and he was bleeding from his wrist. Staff observed that he had put the object into his mouth. He eventually spit out a piece of plastic. Youth Boxer was disciplined for his behavior. 1USvOK114240-114250.

- On that same day, May 8, 2006, youth Verlin Boxer was on suicide watch when he used a "piece of plastic (one report suggested it was part of a coke can)" to cut his upper wrist area. Youth Boxer was taken to the emergency room three hours after the incident and received seven stitches.[4] 1USvOK077354-077355.

- On May 16, 2006, at 8:45 p.m., youth Verlin Boxer was on "severe" suicide watch in the crisis unit, which requires one-to-one supervision. At this time, Boxer was also wearing hand mitts to "redirect his self-abusive behaviors." Although staff Cindy Henderson was assigned to provide the one-to-one supervision, Boxer was able to turn his back to staff Henderson and cut his hand with bathroom tile, requiring a trip to the emergency room and four stitches. The entries during staff Henderson's supervision are all missing from the observation log. An internal review found that Henderson did not fail to give the required level of supervision. 1USvOK077406-077436.

In sum, at this early stage in the litigation, Defendants have already produced documents

[4] The May 8, 2006, incidents are listed as separate incidents because there are multiple incident reports for two apparently different incidents. Due to the poor quality of the report writing, however, it is possible that this incident is actually the same as the one that precedes it.

showing a strong likelihood of success on the merits that Defendants have failed and continue to fail to protect youths at Rader from serious injuries and risk of serious injuries from: (1) rape and sexual assaults; (2) youth-on-youth assaults; (3) excessive use of force and inappropriate restraints; (4) youths' possession of dangerous contraband; and (5) suicide and self-harm.

IV. IRREPARABLE INJURY

Beyond the likelihood of success on the merits, this Court should consider whether irreparable injury will occur without the preliminary injunction. Summum, 483 F.3d at 1048. The above examples show that Defendants do not adequately protect youths from irreparable injuries, and the overwhelming number of incidents in this pattern shows that these injuries will continue without systemic changes.

"A plaintiff suffers irreparable injury when the court would be unable to grant an effective monetary remedy after a full trial because such damages would be inadequate or difficult to ascertain." Kikumura v. Hurley, 242 F.3d 950, 963 (10th Cir. 2001) (citing Tri-State Generation & Transmission Assoc. v. Shoshone River Power, Inc., 874 F.2d 1346, 1354 (10th Cir. 1989)). When, as here, "an alleged constitutional right is involved, most courts hold that no further showing of irreparable injury is necessary." Kikumura, 242 F.3d at 963 (quoting 11A Charles Alan Wright, et. al., Federal Practice and Procedure § 2948.1 (2d ed. 1995)). Moreover, because the United States is proceeding under Section 14141, which specifically authorizes injunctive relief, this Court should presume irreparable injury. See Kikumura, 242 F.3d at 963 ("When the evidence shows that the defendants are engaged in, or about to be engaged in, the act or practices prohibited by a statute which provides for injunctive relief to prevent such violations, irreparable harm to the plaintiffs need not be shown.") (quoting Atchison, Topeka & Santa Fe Ry. Co. v. Lennen, 640 F.2d 255, 259 (10th Cir. 1981)). Even without these

presumptions, the injuries are irreparable standing alone.

The rapes and sexual assaults cause physical and possibly permanent mental damage that money cannot effectively remedy. See Coker v. Georgia, 433 U.S. 584, 611-12 (1977) (Burger, C.J., dissenting) (finding that rape causes serious psychological and physical harm, and likely has an irreparable long range effect).

Similarly, the pain and suffering from the assaults and the danger from the excessive uses of force, improper restraints, and contraband constitute irreparable harm. See Jones 'El v. Berge, 164 F. Supp. 2d 1096, 1123 (W.D. Wis. 2001) (holding that "pain, suffering and the risk of death" constitute irreparable harm sufficient to support a preliminary injunction in prison cases) (citing Von Colln v. County of Ventura, 189 F.R.D. 583, 598 (C.D. Cal. 1999) ("Defendants do not argue that pain and suffering is not irreparable harm, nor could they.")). The above examples of youth-on-youth assaults, and excessive force and improper restraints by staff or other youths have resulted in grave physical harm in the form of contusions, lacerations, broken bones, unconsciousness, and emergency room visits, that likely could cause permanent damage or even death. Moreover, many of the above examples of illegal restraints involved choking, asphyxiation, and seizures that could have resulted in death. See Duran v. Anaya, 642 F. Supp. 510, 526-27 (D.N.M. 1986) (preliminarily enjoining prison from cutting security staff because resulting increased rates of physical assault, rape, and other forms of violence constitute irreparable harm). The inherent safety risks of youths participating in restraints of other youths, as evidenced above, may cause serious injuries to both youths involved in the restraint.

Regarding self-harm and attempted suicide, the above examples show that conditions present a continuing imminent risk of this physical harm to the youths. The repeated attempts of several youths to commit suicide and Defendants' failure to decrease the imminent risks of

suicide notwithstanding, thankfully, there has not yet been a successful suicide at Rader. As depicted above, this self-injurious and suicidal behavior often ends in large cuts, stitches, emergency room visits, and even surgery. See Duran, 642 F. Supp. at 526-27 (preliminarily enjoining prison from reducing medical and mental health care staff because resulting deaths, extreme pain, and self-mutilation constitute irreparable harm). These repeated serious suicide attempts show that, if no action is taken, in addition to the serious injuries from suicide attempts, strong likelihood exists that a youth may successfully kill himself before the trial in April 2008.

This Court should order the remedies below to prevent future irreparable harms. See Hellig v. McKinney, 509 U.S. 25, 33-34 (1993) (holding that an inmate need not wait until after a tragic event occurs to seek an injunction to remedy unsafe prison conditions); Ramos v. Lamm, 639 F.2d 559, 572 (10th Cir. 1980) (finding that a prisoner need not wait until he is actually assaulted before obtaining injunctive relief remedying unsafe conditions).

V. REQUESTED RELIEF

To remedy the risk of future unconstitutional rapes and sexual assaults, the United States requests, at a minimum, that the Defendants:

a. provide increased staff supervision and higher levels of supervision for youths with sexual offenses, predatory behavior, and other high-risk youths;

b. control access and egress to sleeping quarters, including an alarm system to detect unauthorized movement and staggering the times for staff patrols;

c. strictly monitor access to all bathrooms, showers, and other areas outside of staff line of sight;

d. institute policies and procedures for prompt, adequate investigations of rape, sexual assaults, and inappropriate sexual relationships, irrespective of youth recantations;

e. perform adequate background checks of staff, beyond the current intrastate database, to include a full NCIC check;

f. define guidelines for inappropriate relationships between staff and youths, and institute clear guidelines for staff punishment;

g. institute an adequate confidential reporting system for staff to report sexual misconduct by other staff;

h. institute a toll-free hotline for youths, their parents or guardians, and/or their attorneys to contact and report allegations of sexual misconduct; and

i. institute a system to analyze data to target problem areas to prevent future occurrences.

To remedy the unconstitutional risk of future harm from youth assaults, excessive uses of force and improper restraints, and contraband, the United States requests that the Defendants institute, at a minimum, the following measures:

a. provide increased staff supervision and higher levels of supervision for youths with predatory behavior and other high-risk youths;

b. control access and egress to sleeping quarters, including an alarm system to detect unauthorized movement and staggering the times for staff patrols;

c. strictly monitor access to all bathrooms, showers, and other areas outside of staff line of sight;

d. institute policies and procedures for prompt, adequate investigations of assaults and contraband;

e. immediately, and periodically, provide adequate competency-based training for all staff on the proper use of force and acceptable restraints;

f. adequately investigate all incidents of violence, use of force, restraints, and serious injuries, and take appropriate corrective action in response to findings;

g. immediately cease youth-on-youth restraints;

h. institute a system to analyze data to target problem areas to prevent future occurrences;

i. institute a toll-free hotline for youths, their parents or guardians, and/or their attorneys to contact and report allegations of assaults;

j. conduct and document unannounced random searches of both youths and facility units;

k. implement adequate search procedures for youths returning from vocational programs, visits, and off campus activities;

l. establish and document regular inspection mechanisms to monitor the proper management by staff of tools, hazardous chemicals and cleaning agents, and inventories;

m. review contraband incidents and establish corrective actions including staff training and accountability for complying with required security practices; and

n. institute a system of review to analyze data to target problem areas to

prevent future occurrences.

To remedy the risk of future unconstitutional suicides and self-harm, the United States requests, at a minimum, that the Defendants:

a. immediately, and periodically, provide all direct care, medical, and mental health care staff with adequate suicide and self-harm prevention training, which stresses juvenile suicide research, potential predisposing factors to self harm, high-risk suicide periods, and warning signs and symptoms;

b. increase communication and documentation between staff regarding youths on suicide precautions;

c. perform routine inspections to ensure that suicidal youths are housed in suicide-resistant rooms and do not have access to suicide hazards such as broken tiles;

d. ensure that mental health staff perform daily assessments of youths on suicide precautions;

e. require unit managers to closely review Suicide Precaution Observation Records to ensure that direct care staff are observing suicidal youths as required;

f. require mental health care staff to review proposed youth disciplinary measures and cease punishing youths for attempted suicide, self-harm, and other indicators of mental health problems; and

g. ensure that youths who indicate they may engage in self-harm receive prompt and adequate treatment from a qualified mental health professional.

As the Defendants' documents show above, youths at Rader are subjected to irreparable harm and risk of harm daily. This pattern of harm continues, and in some cases increased, despite the United States' notification to Defendants of similar egregious incidents and systemic failures and minimal remedial measures in June 2005. Accordingly, this Court should order such equitable relief as necessary to enforce all remedies, e.g., direct periodic reporting to the Court and appointment of a neutral third-party to review and verify implementation of necessary remedies.

VI. BALANCE OF HARMS

This Court must next determine whether the above threatened irreparable injuries outweigh whatever damage the proposed injunction may cause the Defendants. Summum, 483 F.3d at 1048. The severe injuries exemplified above all heavily outweigh the costs to the Defendants of remedying the unsafe conditions.

These injuries include rape, which "[s]hort of homicide, [ ] is the ultimate violation of self." Coker, 433 U.S. at 597 (plurality) (internal quotation marks omitted); id. at 612 (Burger, C.J., dissenting). Beyond the rapes, the youth assaults, staff excessive force and improper restraints, and contraband cause severe physical injuries, including lacerations, broken bones, asphyxiation, seizures, contusions, unconsciousness, and emergency room visits. The attempted suicides and self-harm cause large cuts, stitches, emergency room visits, and even surgery - and possibly death.

Conversely, the requested relief will only cause the Defendants the minimal additional administrative costs necessary to ensure the safety of the youths. The physical and emotional damage to the youths, however, drastically outweighs these administrative costs. Ramos, 639 F.2d at 574 n.19 ("The lack of funding is no excuse for depriving inmates of their constitutional

rights."); R.G. v. Koller, 415 F. Supp. 2d 1129, 1162 (D. Haw. 2006) (granting preliminary injunction because, "[w]hile requiring defendants to adopt polices, procedures, and training so as to provide . . . a reasonably safe environment . . . may impose some administrative inconvenience, any burden on the defendants is minimal when viewed in light of defendants' legal responsibility to provide a safe environment."); see also Hadix v. Caruso, 461 F. Supp. 2d 574, 596-98 (W.D. Mich. 2006) (ordering, because of prison's inadequate mental health care, a preliminary injunction that required increased staff, training, staff rounds, mental health protocols, and meetings).

Moreover, increased youth supervision, fewer youth assaults, and the decrease in contraband will increase the safety of Rader staff, which could significantly help to address the facility's understaffing problem. Therefore, the balance tips decidedly in favor of reducing the unconstitutionally unsafe conditions.

VII. PUBLIC INTEREST

Last, this Court must determine that the preliminary injunction would not be adverse to the public interest. Summum, 483 F.3d at 1048. This factor weighs unquestionably in favor of the preliminary injunction, because "there is the highest public interest in the due observance of all the constitutional guarantees." United States v. Raines, 362 U.S. 17, 27 (1960). Beyond the Constitution, Congress highlighted the public interest in protecting juveniles from these types of harms when it enacted 42 U.S.C. § 14141.

A safe environment serves the public interest in protecting and rehabilitating its youths. The above remedies will provide a safer environment by helping protect youths from physical assaults and physical harm, including rapes, assaults, excessive force, self harm, and suicides. It is axiomatic that the public has no interest in seeing its youths raped, physically assaulted, or

physically harmed. While the public has an interest in confining and rehabilitating these youths, that interest is only served when the State uses proper force and restraints, and maintains a safe environment for the youths. See National Ass'n of Psychiatric Health Systems v. Shalala, 120 F. Supp. 2d 33, 45 (D.D.C. 2000) (finding public interest served by reducing inappropriate restraints because they cause severe psychological and physical injuries). The above remedies will also help serve the public interest by improving both the mental and physical well being of the youths. Jaffee v. Redmond, 518 U.S. 1, 11 (1996) ("The mental health of our citizenry, no less than its physical health, is a public good of transcendent importance."). Thus, the public interest strongly supports the protection of the youths from the unsafe conditions caused by rape, youth assaults, excessive use of force and improper restraints, dangerous contraband, and attempted suicide and self harm.

VII. CONCLUSION

Defendants' own documents show an immediate and on going pattern or practice of harm and imminent risk of harm at Rader. These documents show that Defendants continually subject youths at Rader to risk of serious injuries from: (1) rape and sexual assaults; (2) assaults by other youths; (3) excessive use of force and inappropriate restraints by staff; (4) youths' possession of dangerous contraband; and (5) suicide and self-harm. The balance of the equities strongly supports a preliminary injunction to decrease the imminent risk of these harms. Accordingly, the United States respectfully moves this Court to enter a preliminary order requiring the above requested remedies.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that today I caused a copy of the UNITED STATES' MOTION FOR PRELIMINARY INJUNCTION in United States of America v. State of Oklahoma, et al., Civil Action No. 06-CV-673-GKF-FHM, to be served to the following individuals via electronic filing:

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Dated this 15th day of August, 2007.

s/ Stacey K. Grigsby
STACEY K. GRIGSBY, ESQ.

ATTACHMENT A

U.S. Department of Justice

Civil Rights Division

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

June 8, 2005

The Honorable Brad Henry
Governor
State of Oklahoma
State Capitol Building
2300 N. Lincoln Blvd., Room 212
Oklahoma City, OK 73105

Re: Investigation of the L. E. Rader Center, Sand Springs, Oklahoma

Dear Governor Henry:

I write to report the findings of the Civil Rights Division's investigation of conditions at the L. E. Rader Center ("Rader") in Sand Springs, Oklahoma. On March 31, 2004, we notified you of our intent to conduct an investigation of Rader pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, and the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141 ("Section 14141"). As we noted, both CRIPA and Section 14141 give the Department of Justice authority to seek a remedy for a pattern or practice of conduct that violates the constitutional or federal statutory rights of children in juvenile justice institutions.

The level of cooperation from the Office of Attorney General ("OAG") has been mixed. The OAG provided the United States with some of the documents we requested. Specifically, the OAG provided us with incident reports, youth grievances, disciplinary reports, and abuse investigations from January 1, 2003 to May 30, 2004. The OAG would not, however, produce the medical reports that the facility generated during the same time period. The lack of medical reports severely limited our ability to assess the number and severity of injuries that youth at Rader suffered following juvenile assaults, staff abuse, and incidents of self-injurious behavior.

More importantly, the OAG refused to allow the United States the opportunity to tour the Rader facility to observe operations and interview staff and residents. From April 2004 to February 2005, the United States attempted to work with the OAG to address any concerns and ensure that our tour would not disrupt operations at Rader. The OAG repeatedly refused to permit the United States to tour the facility. This lack of cooperation severely impeded our investigation.

By law, our investigation must proceed regardless of whether officials choose to cooperate fully. Indeed, when CRIPA was enacted, lawmakers considered the possibility that state and local officials might not cooperate in our federal investigation. See H.R. CONF. REP. 96-897, at 12 (1980), reprinted in 1980 U.S.C.C.A.N. 832, 836. Such non-cooperation is a factor that may be considered adversely when drawing conclusions about a facility. See id. We now draw such an adverse conclusion.[1]

Consistent with the statutory requirements of CRIPA, I now write to advise you of the findings of our investigation, the facts supporting them, and the minimum remedial measures that are necessary to address the deficiencies we have identified. As described more fully below, we conclude that the conditions of confinement violate the constitutional rights of youth confined at Rader. In particular, we find that, based on constitutionally deficient practices, Rader fails to protect children from harm or the risk of harm.

I. BACKGROUND

The State of Oklahoma ("State"), through its Office of Juvenile Affairs ("OJA"), operates Rader, the largest secure juvenile justice facility in the State. Rader has bed space for approximately 215 juveniles who have been adjudicated delinquent and are 19 years of age or younger. Although Rader housed both male and female youth at the inception of our investigation,

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[1] The State's non-cooperation constitutes only one factor that we consider in preparing our statutory findings and recommendations. We also have considered the documentation provided by the State, reports issued by the American Correctional Association ("ACA"), news articles, and interviews with private attorneys, public defenders, and local law enforcement officers.

recent news reports indicate that OJA removed all girls from the facility in February 2005.

II. FINDINGS

As a general matter, States must provide confined juveniles with reasonably safe conditions of confinement. See Youngberg v. Romeo, 457 U.S. 307, 315-24 (1982); Bell v. Wolfish, 441 U.S. 520, 535-36 & n.16 (1979). As the Tenth Circuit stated in Yvonne L. v. New Mexico Dept. of Human Serv., 959 F.2d 883 (10th Cir. 1992), "juveniles involuntarily placed in a private school by state agencies or a court [have] liberty interests protected by the Fourteenth Amendment; specifically, '[s]uch [a] person has the right to reasonably safe conditions of confinement.'" Id. at 893-94 (quoting Milonas v. Williams, 691 F.2d 931, 942 (10th Cir. 1982)). As described below, the State has fallen far short of this constitutional obligation.

Our investigation revealed that the State fails to protect youth confined at Rader from harm due to constitutionally deficient practices. Specifically, the State fails to protect youth from: (1) sexually inappropriate relationships with staff and other juveniles; (2) juvenile-on-juvenile violence; (3) self-injurious behavior; (4) inadequate management of psychotropic medication; and (5) excessive use of force by staff.[2]

A. Sexually Inappropriate Relations

Contrary to its legal obligations, the State fails to provide adequate supervision and monitoring to ensure that juveniles at Rader are not subjected to inappropriate sexual relationships with staff or other residents. See Youngberg, 457 U.S. at 324; Yvonne L., 959 F.2d at 893.

1. Sexual Relationships Between Staff and Youth

Documents produced by the State indicated that numerous sexual relationships developed between female staff members and male youth. It appears that in some instances other staff members were aware of these relationships and brought them to the attention of supervisors and administrators. However,

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[2] Except where specifically noted, internal Rader investigations and/or investigations conducted by the Office of Client Advocacy ("OCA") of the Oklahoma Department of Human Services provide the basis for all allegations set forth in this letter.

administrators and supervisors failed to take prompt, appropriate action. Examples of inappropriate sexual relationships between staff and youth include:

- On May 31, 2004, a male youth reported to a client advocate at Rader that a female staff member permitted a youth to carry her into his room and place her on his bed where the youth and others fondled her.[3] The youth reported that the female staff member previously spoke in a sexual manner with youth and permitted them to touch her in inappropriate ways. The documents we received from the State did not indicate whether an internal investigation substantiated the youth's claims regarding the alleged sexual contact, and if so, whether any disciplinary action was taken.

- In the Fall of 2003, female staff member A.W.[4] and a male youth engaged in a sexual relationship. Rader staff found correspondence between the two that confirmed the relationship.[5]

- In September 2003, female staff member N.R. engaged in a sexual relationship with male youth J.J., who was classified as a sex offender. Staff member N.R. and youth J.J. twice engaged in oral sex and digital penetration in the linen closet of the mental health stabilization unit. Staff member N.R. also permitted a different youth, D.Q., to fondle her in front of other youth on the unit. Youth J.J. became very territorial of the staff member and had numerous physical altercations with other youth over her.[6] At least

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[3] A "client advocate" is a staff member at Rader who refers allegations of misconduct to administrators, assists youth with grievances, and represents youth in discipline hearings.

[4] In this letter, we use pseudonym initials of youth and staff in order to protect their identities and privacy.

[5] The OJA Office of Public Integrity ("OPI") conducted an investigation of staff A.W. and found the letters in the course of that investigation. The State did not provide documents from the OPI investigation, so we do not know what action, if any, was taken by the State.

[6] For example, youth J.J. noticed youth L.M. staring at the female staff. Youth J.J. leaped on to a table and kicked youth

eight staff members voiced their concerns to staff member N.R. and to supervisors about staff member N.R.'s behavior. Indeed, one staff member stated that he considered the female staff member to be a "sexual predator." Documents provided by the State indicate that OCA confirmed sexual abuse by staff member N.R.[7] We requested but were not provided documentation regarding any discipline or corrective action taken by the State following this incident.

- Between July 2003 and October 2003, female staff member B.K. and a male youth engaged in inappropriate sexual relations. Staff observed staff member B.K. use her foot to rub the inner thigh of the youth while the two were seated in the day room of the unit. Staff also noted that staff member B.K. spent a great deal of time in the youth's bedroom. Indeed, one staff observed staff member B.K. lying on the youth's bed. Staff reportedly noted the inappropriate relationship early on, yet failed to report it to administrators. Administrators took action to address the relationship after a security staff member intercepted a letter from staff member B.K. to the youth. The letter contained sexually explicit language and included the female staff member's home phone number. Documents provided by the State indicate that OCA confirmed sexual abuse by staff member B.K. Staff member B.K. resigned her employment on October 8, 2003.

- From September 2002 through February 2003, a male youth and female staff member R.G. engaged in a sexual relationship. During this six month period, there was abundant indicia of inappropriate behavior. For example: the female staff member frequently shared her food with the youth; she brought him electronic games and other "goodies;" the youth sent letters to the female staff member at her home address; the female staff member mailed Valentine's Day cards to the youth at Rader; she gave the youth photos of herself; she brought him into the supply closet with her; she entered the youth's room after lights out; she

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L.M. in the face.

[7] OJA refers many allegations of staff misconduct to the OCA. The OCA either conducts its own investigation or sends the matter back to OJA for Rader staff to investigate.

permitted the youth to stay up after hours and spend time with her; she permitted the youth to wear her clothes and shoes; she allowed the youth to place his hand on her thigh in front of other youth; and the female staff member and the youth engaged in horseplay such as swatting and slapping. During this time, three different staff members spoke with the female staff member and other employees wrote memoranda setting forth their concerns about her behavior. Nevertheless, it took six months for administrators to address the relationship. Documents provided by the State indicate that OCA confirmed a finding of sexual abuse against the female staff member. The State terminated staff R.G.'s employment on February 20, 2003.

2. Sexual Relationships Between Youth

Examples of inappropriate sexual relationships between youth include:

- On April 3 and 4, 2004, two male youth reportedly engaged in mutual masturbation while housed on the unit for sex offenders. One of the youth reported that he participated because he feared the other youth would harm him.[8]

- On January 29, 2004, an 18-year-old male youth engaged in anal sex with a 14-year-old male in the restroom of the gym while two staff supervised 13 other youth. The incident occurred while one of the youth was on "close observation" which required staff to know of his whereabouts at all times.[9]

- In August 2003, two female youth engaged in sexual activity in their dormitory on at least one occasion. The two youth were able to engage in sexual activity

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[8] We did not receive a final investigation report from the State regarding this incident. The documents we received indicate that an investigation of this incident was ongoing and that investigators had not reached a final conclusion as to whether the conduct occurred.

[9] Documents provided by the State indicate that OCA did not confirm any allegations of neglect against the staff members charged with supervising the youth, but did confirm that sexual activity had occurred.

because there was only one staff member monitoring the housing unit. The other staff member had left the unit to take a smoking break, in contravention of facility rules. Documents provided by the State indicate that OCA substantiated a finding of caretaker misconduct on the staff member who was derelict from duty. Rader suspended the staff member for three days without pay.

- From at least May 2003 through June 2003, two male youth engaged in a sexual relationship while housed on the sex offender unit. The two youth regularly paired off and engaged in mutual masturbation and oral sex while staff were preoccupied with other youth. Documents provided by the State indicate that OCA substantiated a finding of neglect against one staff member. Rader suspended the staff member for three days without pay.

- On January 26, 2003, two youth classified as sexual offenders left the day room of their unit and entered one of the bathrooms. The two youth then engaged in oral and anal sex. Although three staff were on duty, two staff were dealing with a youth who was acting out in his room and the third staff was monitoring the day room. OCA investigated the incident and did not confirm caretaker misconduct, but did confirm sexual activity.

B. Youth-on-Youth Violence

The State must provide youth confined at juvenile justice facilities with reasonably safe conditions including protection from assault by other youth. See Youngberg, 457 U.S. at 324; Yvonne L., 959 F.2d at 893. Incident reports provided by the State between January 1, 2003 and May 30, 2004, demonstrated that a significant number of juveniles were involved in youth-on-youth violence.[10] Many of the assaults and injuries at Rader occurred

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[10] We are aware that the ACA reaccredited Rader in September 2003. We are also aware that the ACA conducted one-day monitoring tours of Rader in September 2004 and March 2005 in response to problems identified in a report by the Oklahoma Commission on Children and Youth. Following the March 2005 tour, the ACA issued a report in which it noted a downward trend in the level of violence at Rader. Without touring the facility, however, we are unable to verify whether a meaningful reduction in violence has occurred.

because staff failed to adequately supervise youth. Other assaults and injuries occurred because staff lacked the knowledge and/or training to safely intervene once fights occurred. Except where indicated, the following examples are taken from the documents provided by the State:

- On June 18, 2004, a local newspaper reported that a brawl broke out among seven youth who were members of rival gangs. One youth suffered a broken jaw and another youth suffered a broken arm. Five other residents were injured. Ten staff members were taken to a local hospital to treat injuries they suffered.

- On May 16, 2004, youth T.E. and youth G.L. argued at the gym. In response, staff sent the two youth back to the dorm. Inexplicably, staff sent them to the dorm unescorted. When they arrived at the dorm, youth G.L. attacked youth T.E. The one staff person on duty in the dorm refused to break up the fight. Instead, she ordered other juveniles to intervene. Youth T.E. received a bruised left eye from this incident. Documents provided by the State indicate that OCA requested that Rader officials investigate the incident. To the extent that an internal Rader investigation exists, the State did not provide us with a copy.

- On May 14, 2004, youth F.D. and youth P.Z. fought for several minutes in youth P.Z.'s bedroom. The fight continued until another youth, M.B., broke it up. Youth F.D. suffered two black eyes from the incident. Staff were unaware that the fight had occurred. Documents provided by the State indicate that OCA requested that Rader officials investigate the incident. To the extent that an internal Rader investigation exists, the State did not provide us with a copy.

- On May 8, 2004, youth E.N. and youth G.L. entered the bathroom and began to fight. Staff were not aware that the fight had occurred until other youth told staff that youth G.L. was in the bathroom and that his nose was bleeding. Rader staff transported youth G.L. to the emergency room where medical personnel determined that he had a broken nose. Documents provided by the State indicate that OCA would conduct an investigation. To the extent that OCA did conduct an investigation, the State did not provide us with a copy.

- On May 7, 2004, youth H.R. approached youth P.Z. from behind, choked him, and slammed him to the ground. Youth P.Z. claimed that there were staff in the room, but they did not intervene. Instead, another youth eventually broke up the fight. Youth P.Z. suffered a black eye from the incident. Documents provided by the State indicate that OCA requested that Rader officials investigate the incident. To the extent that an internal Rader investigation exists, the State did not provide us with a copy.

- On April 29, 2004, a series of youth-on-youth assaults occurred on the Mental Health Stabilization Unit ("MHSU"). Staff stated in incident reports that: "We did not/do not believe that we can keep juveniles on this unit safe."

- On January 17, 2004, youth A.C. claimed that three youth entered his room and assaulted him. Youth A.C. claimed that several minutes passed before staff realized what was happening and responded to the incident. Youth A.C. suffered an abrasion above his right eye from the incident. Documents provided by the State indicate that OCA requested that Rader officials investigate the incident. To the extent that an internal Rader investigation exists, the State did not provide us with a copy.

- On November 24, 2003, youth V.S. assaulted youth J.J. in the shower. The OCA investigated the incident and confirmed that inadequate staff supervision made it possible for the assault to occur. Rader staff took youth J.J. to the emergency room where he received treatment for bruises to his body. OCA confirmed a charge of caretaker misconduct against staff D.U., and staff D.U. received a written reprimand and a corrective action plan.

- On July 30, 2003, youth K.V. assaulted youth I.O. while staff W.T. and staff C.X. were on duty. Staff W.T. intervened and all three fell to the floor. Staff W.T. restrained youth K.V. and released youth I.O. Several residents kicked youth K.V. and staff W.T. while they lay on the floor. Documents produced by the State indicate that staff C.X. did not attempt to assist staff W.T. or protect youth K.V. OCA confirmed a

charge of neglect against staff C.X., and staff C.X. received a three-day suspension without pay and a corrective action plan.

Disturbingly, and in a gross departure from sound practices, it appears that in some cases the staff either actively encouraged a fight to occur or had knowledge that a fight would occur and allowed it to happen. For example:

- On April 16, 2004, youth Y.A. assaulted youth O.U. in the kitchen area while four other youth watched. Youth O.U. suffered facial bruises, a bloody nose and mouth, and a cut on his neck. The youth claimed that a staff member, who was seated only a few feet away when the fight occurred, permitted the fight to continue. Documents provided by the state indicate that OCA confirmed staff neglect and inadequate supervision of youth. The documents also indicate that the staff member is no longer employed at Rader. It is unclear from the documents, however, whether Rader terminated the staff member as a result of this incident or whether he left employment voluntarily.

- On February 14, 2004, a staff member verbally encouraged youth J.J. and youth B.G. to settle their differences by going into their cells and fighting. The staff member stood outside the locked cell door and watched as the two youth fought. The staff member did not unlock the door and intervene until after youth B.G. grabbed youth J.J.'s head and brought it down on his knee.[11] Rader staff transported youth J.J. to the emergency where medical staff diagnosed him with a broken nose and a closed head injury with a bruise to his left eye and forehead. Documents provided by the State indicate that OCA confirmed the allegation of abuse with injury. In addition, the OCA investigation indicated that the staff member verbally encouraged the alteration and observed part of the fight. We requested but were not provided documentation regarding any discipline or corrective action taken by the State following this incident.

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[11] Youth also reported that the staff members on duty spoke about reporting the incident as either horseplay or an accident in the shower. Neither staff member filed reports about the incidents although they were required to by facility rules.

There are other indications that the State fails to properly supervise youth at Rader. A local newspaper reported on October 24, 2004 that 15 youth had escaped from Rader or gone AWOL. Indeed, the article stated that on October 16, 2004 two youth escaped from Rader by prying open a locked door and scaling the facility's perimeter security fence. Most recently, the newspaper reported that on March 13, 2005, two 14-year-old youth escaped from Rader by overpowering a staff member, stealing her keys, and scaling two different fences.

Finally, the lack of adequate supervision makes it possible for an excessive quantity of contraband to be introduced into the facility. The failure to adequately control contraband places both staff and youth at risk of harm. See LaMarca v. Turner, 995 F.2d 1526, 1532-37 (11th Cir. 1992) (finding that excessive contraband contributes to an unsafe environment for inmates). In an institutional setting, contraband is often used either as a weapon or as currency. According to documents provided by the State, contraband appears to be readily accessible to juveniles at Rader, and is regularly used as a weapon, potential weapon, or currency in the facility. For example:

- On September 19, 2004, a youth attacked another youth and a staff member with a four-foot long piece of metal.
- In May 2004, staff searched a youth's room and found a metal rod hidden in his mattress.
- In October 2003, staff searched the girls' unit and found drugs and drug paraphernalia.
- In June 2003, staff searched a youth's room after he had taken a psychotropic medication intended for another youth. In his room, they found, among other things, batteries and bleach.[12]
- In May 2003, three youths tested positive for marijuana. A search of a youth's room uncovered marijuana and a lighter.

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[12] A youth could make a weapon by placing the batteries in a sock and swinging the batteries at an individual. Further, a youth easily could harm himself or others by swallowing or hurling bleach. Indeed, one youth attempted to poison a staff member by pouring bleach into the beverage of a staff member.

- In April 2003, staff found a razor blade hidden in a vent in a youth's cell.

- On January 6, 2003, staff searched the room of a male youth and found money, rolling papers, cigarettes, a lighter, pornography, materials used in making tattoos (including a bloody rag), and pills.

C. Self-Injurious and Suicidal Behavior

The State also fails to protect youth at Rader who engage in suicidal and self-injurious behavior. See Youngberg, 457 U.S. at 324; Yvonne L., 959 F.2d at 893.

1. Suicide

In 2003 and 2004, youth at Rader made at least 12 suicide attempts at the facility. In each case, staff failed to take adequate precautions to protect the youth from harm. For example:

- On March 21, 2004, a youth cut his wrist with the metal from a pencil eraser and pulled out stitches previously sutured. With the blood from his wounds, the youth wrote the words "with pain" and "die" on the wall over his bed. The youth then used a rope made from a towel and his shirt and tried to strangle himself. OCA investigated the incident and did not confirm neglect by the staff members supervising the youth.[13]

- On February 24, 2004, a youth went to his room, closed the door, tied his belt around his neck, and tried to hang himself. Staff did not realize that the youth was attempting suicide until he fell to the ground and yelled out in pain, as he had chipped a bone in his ankle. An internal investigation confirmed that staff failed to properly supervise the youth. We requested but were not provided documentation regarding any discipline or corrective action taken by the State following this incident.

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[13] The OCA investigators accepted the staff members' representations that they checked on the youth every 15 minutes. However, the staff members failed to document these checks. Indeed, they claimed that they were not required to document the checks even though facility policy explicitly requires staff to do so.

- On August 19, 2003, a youth on the MHSU cut himself and staff placed him on suicide watch. On August 20, 2003, the youth, who was on "close observation," went to his room without supervision and closed the door. Once alone, he tore up his shirt, fashioned the strips into a noose, and tied it around his neck. Staff found the youth lying on the floor of his room with red marks around his neck.[14] OCA investigated the incident and did not confirm neglect by the staff members supervising the youth.

- On April 10, 2003, staff discovered that a youth had tried to commit suicide by tying a string about his neck. At the time, the youth was on suicide watch and wearing a helmet and suicide smock to prevent acts of self harm. The youth had tied a string to his helmet, wound it around his neck, and tied the string to his toe. Staff discovered the youth while distributing medication. A staff member was unable to untie the string and, instead, burned the string with a lighter he was carrying. Documents provided by the State do not indicate whether either OCA or Rader officials investigated the incident.

  Two months earlier, on February 8, 2003, staff found the same youth underneath the desk in his cell. Staff initially thought that he was sleeping. However, he would not respond to verbal commands to wake up. Staff soon realized that the youth was unconscious and had wrapped a shoelace around his neck and attached it to his toe. A staff member used a lighter to burn the shoelace. Documents provided by the State do not indicate whether either OCA or Rader officials investigated the incident.

- On January 16, 2003, a youth cut both his wrists with a piece of metal. Staff placed the youth in the day room for closer observation. An hour later, the youth tried to strangle himself by tying his pillow case around his neck and strangling himself. Documents provided by the State do not indicate whether either OCA or Rader officials investigated the incident.

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[14] At the time of the incidents, the mental health stabilization unit did not have policies or procedures governing its operations.

2. Self-Injurious Behavior

In addition to the attempted suicides, we found many examples of youth who engaged in self-injurious behaviors. From January 1, 2003 to May 30, 2004, there were over 35 documented reports of youths punching walls or furniture, banging their heads against floors and windows, or beating themselves with objects. In most cases, it appears that staff at Rader are not monitoring adequately children who have a repeated history of engaging in self-abusive behaviors. The injuries ranged from bruises and scratches to fractures.[15] For example:

- On May 28, 2004, a male youth on close supervision managed to wander into an unauthorized area. The youth became upset and struck a window. Rader transferred the youth to the hospital where medical staff stitched the wound.[16] In the 18 months prior to this incident, the youth repeatedly engaged in self-injurious behavior. Incident reports document seven instances where the youth struck an inanimate object; five instances where the youth inserted metal into his skin and/or used metal to cut himself, and one instance where he swallowed ink.

- On May 5, 2004, a male youth inserted a two-inch section of paper clip into his left forearm. Staff did not realize this until three days later.[17] Staff should have been more vigilant to prevent the youth from hurting himself given that the youth had harmed himself numerous times before. In the nine months prior to this incident, the youth twice punched out the

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[15] Youth appear to have engaged in these behaviors either to hurt themselves or to vent their frustrations. For example, on May 1, 2004, when staff asked a youth about a bruise on his head, he stated that he had beaten his head against the wall in order to relieve stress.

[16] Documents provided by the State indicate that OCA requested that Rader officials investigate this incident. To the extent that an internal Rader investigation exists, the State did not provide us with a copy.

[17] Documents provided by the State indicate that OCA requested that Rader officials investigate this incident. To the extent that an internal Rader investigation exists, the State did not provide us with a copy.

windows in doors and at least five times either cut himself or inserted metal into his skin. During one incident, staff heard the youth singing "cut, cut, cut!" in his room. Staff entered the room and found that he had cut a "gaping hole" in his arm. At the time, the youth was supposed to be on close observation because of an incident earlier in the day in which he was sent to the hospital after inserting a paper clip under the skin in his arm.

D. Failure to Safely Distribute Psychotropic Medication

The State fails to monitor adequately the distribution of psychotropic medication to mentally ill youth at Rader. See Youngberg, 457 U.S. at 324. See also Coleman v. Wilson, 912 F.Supp. 1282, 1309-10 (E.D. Ca. 1995) (finding defendants' system of medication management unconstitutional based, in part, on their failure to monitor adequately the hoarding of psychotropic medication). Based on a review of documents produced by the State, we found that students regularly hoard medication and either share it with or sell it to other youth. In addition, the nursing staff, at times, appear to provide youth with the inappropriate type or dosage of medication. For example:

- In April 2004, staff found a male youth sitting in a chair in his room. The youth was non-responsive to verbal commands. The staff shook him, but he would not respond. Rader staff transported the youth to the hospital. Documents provided by the State indicate that the youth had consumed seven pills of prescription medication prescribed to another youth.

- In September 2003, a youth provided two pills of a psychotropic medication and two pills of an anti-depressant to two other youth who crushed the pills and snorted them.

- On August 11, 2003, a male youth swallowed eight pills during medication distribution. Over a two-week-period the youth had "cheeked" some of his own medication and had received prescription medication from other youth.[18] The youth hid the medication in his room.

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[18] A youth "cheeks" oral medications by hiding the medication either in the cheek or under their tongue to prevent swallowing. The youth later spits out the medication and either hides it, gives it away, or sells it to another youth.

- On July 20, 2003, a male youth provided 13 pills to three other youth. The three youth took the pills without knowing what they were. One youth, with slurred speech, informed staff that he wanted to fly like Superman.

- On June 17, 2003, a male youth took a psychotropic mediation that was meant for another youth. He was taken to the hospital for detox.

- On May 3, 2003, a nurse gave a male youth the wrong medication during pill distribution. The youth informed the nurse that it was the wrong medication, but the nurse insisted that it was correct. The nurse later realized that the youth had, in fact, received the wrong medication.

E. Excessive Force by Staff

Staff at Rader physically restrain youth with great frequency. Staff legally are permitted to employ physical force when youth pose an immediate risk of harm either to themselves or to others. See Youngberg, 457 U.S. at 324; Yvonne L., 959 F.2d at 893; Milonas, 691 F.2d at 942-43. The amount or level of force used, however, should be the least amount necessary to control the situation and prevent injury to staff and youth. Our review of documents produced by the State indicates that Rader staff employed force that was disproportionate to the threat posed by the youth. The following examples are illustrative:

- On March 15, 2004, in response to male youth R.W. trying to push past him, staff E.V. picked him up and threw him to the ground on his back. The youth, who is six inches shorter and weighs 100 pounds less than the staff member, suffered a one-inch cut over his eye that required three sutures to close as well as bruises and abrasions. An OCA investigation confirmed staff misconduct by staff E.V. We requested but were not provided documentation regarding any discipline or corrective action taken by the State following this incident.

- On December 12, 2003, a female staff member and a male youth argued over the placement of his bed in the day room. At one point, the staff member called the youth a "bad ass bastard" and told the youth that he would die while incarcerated. The staff member walked over

to the youth and slapped a cup out of his hand. In the process, the staff member struck the youth in the face. Other staff approached and restrained the staff member. The staff member attempted to break free and attack the youth. Security staff arrived on the unit and placed the staff member in another room where she proceeded to curse, pace, and verbally threaten to harm the youth. Security staff reported that the staff member called the youth a "bitch ass nigger" and challenged him to "do something or shut up." An OCA investigation confirmed abuse by the female staff member. She resigned her position in lieu of termination.

- On November 9, 2003, staff E.V. grabbed youth B.G. by the wrist and threw him to the floor after youth B.G. refused a direct order. The youth suffered swelling and redness to the temple area. The OCA investigation confirmed that the staff member used excessive force and that the youth did not pose a risk to anyone at the time that force was used. We requested but were not provided documentation regarding any discipline or corrective action taken by the State following this incident.

- On May 10, 2003, youth C.P. repeatedly requested a snack from staff T.B. Staff T.B. became angry and lunged at youth C.P., pushing the youth backwards towards the kitchen door. Staff T.B. then picked up youth C.P. and tried to throw him over his shoulder. Staff T.B. and youth C.P. fell to the floor where staff T.B. struck youth C.P. in the head and ribs. Staff M.Q. responded to the altercation and made repeated attempts to strike youth C.P. with his forearm. At the same time, staff T.B. exerted pressure to youth C.P.'s throat. Security staff arrived and attempted to intervene. Staff T.B. and staff M.Q. pushed security staff away and continued to try to fight youth C.P. even though youth C.P. was not fighting back. At one point, staff M.Q. attempted to strike youth C.P. but, instead, hit security staff K.O. in the jaw. An OCA investigation confirmed abuse by staff M.Q. and staff T.B. Staff D.O. resigned in lieu of termination and Rader terminated the employment of staff T.B.

III. REMEDIAL MEASURES

In order to rectify the identified deficiencies and protect the constitutional rights of youth confined at Rader, the State should implement, at a minimum, the following remedial measures:

1. Ensure that youth are adequately protected from inappropriate sexual interaction with staff and other youth.

2. Ensure that youth are adequately protected from physical violence committed by staff and other youth.

3. Ensure that there are sufficient, adequately trained staff to safely supervise youth.

4. Ensure that staff are adequately trained in safe restraint practices and that restraints are used only in appropriate circumstances.

5. Ensure that staff adequately and promptly report incidents of violence and misconduct.

6. Ensure that all incidents of violence, use of force, or serious injury are adequately investigated and that appropriate personnel actions are taken in response to substantiated findings.

7. Develop and implement adequate policies and procedures to ensure that youth who are at risk of suicide and youth who are at risk of engaging in self-injurious behavior are properly identified, supervised, and treated.

8. Develop and implement adequate policies and procedures to ensure that medication is safely distributed and administered to youth.

9. Develop and implement adequate policies and procedures to prevent the introduction of contraband into the facility.

* * * * * * * * * * *

I invite the State to discuss with us the remedial recommendations, with the goal of remedying the identified deficiencies without resort to litigation. In the event that we are unable to reach a resolution regarding our concerns, the Attorney General is empowered to institute a lawsuit pursuant to

CRIPA to correct deficiencies of the kind identified in this letter, 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1).

We would prefer, however, to resolve this matter by working cooperatively with you. We have every confidence that we will be able to do so in this case. The lawyers assigned to this matter will contact your attorneys to discuss this matter in further detail. If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

R. Alexander Acosta
Assistant Attorney General

cc: The Honorable Drew Edmondson
Oklahoma Attorney General
Office of the Oklahoma Attorney General

Charles N. Nobles
Chairman
Board of Juvenile Affairs

Richard DeLaughter
Executive Director
Office of Juvenile Affairs

Jimmy Martin
Superintendent
L.E. Rader Center

The Honorable David E. O'Meilia
United States Attorney
Northern District of Oklahoma

ATTACHMENT C

OFFICE OF ATTORNEY GENERAL
STATE OF OKLAHOMA

July 22, 2005

Mr. Bradley J. Schlozman
Acting Assistant Attorney General
U.S. Department of Justice
950 Pennsylvania Avenue N.W.
Washington, D.C. 20530

Re: Investigation of the L.E. Rader Center, Sand Springs, Oklahoma

Dear Mr. Schlozman:

I am writing in response to the letter from R. Alexander Acosta, Assistant Attorney General, Civil Rights Division, dated June 8, 2005, addressed to The Honorable Brad Henry, Governor of the State of Oklahoma, referencing the Investigation of the L. E. Rader Center, Sand Springs, Oklahoma.

In his letter, Mr. Acosta holds open the possibility of a CRIPA lawsuit against the State of Oklahoma, unless the State corrects certain identified deficiencies. These alleged deficiencies are listed as:

Sexually Inappropriate Relations;
Youth on Youth Violence;
Self-Injurious and Suicidal Behavior;
Failure to Safely Distribute Psychotropic Medication; and
Excessive Force by Staff.

Under each heading, Mr. Acosta described various incidents to support his conclusion that the alleged deficiencies exist. At the end of the letter, Mr. Acosta provided a boilerplate list of remedial measures he believes the State of Oklahoma, at a minimum, should implement.

Mr. Acosta's letter contains incomplete and inaccurate information which has led him to make an inaccurate assessment of the functioning of the L.E. Rader Center.

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A broad request for documents resulted in ten boxes of documents being copied and sent to Mr. Acosta. Contrary to Mr. Acosta's assertions, this office requested that the Oklahoma Office of Juvenile Affairs provide medical records related to your investigation in the general areas identified to us. There was only one request made for additional medical records concerning an alleged use of isolation as punishment against a moderately mentally retarded, self-mutilating juvenile. The medical records and all investigation reports concerning this incident were furnished to Mr. Acosta. We also requested any technical assistance Mr. Acosta's office could provide in responding to the incident. No response was received from his office.

Mr. Acosta stated that this office refused to allow the Department of Justice the opportunity to tour the facility to observe operations and interview staff and residents. This is inaccurate. In my last correspondence with Mr. Daly, the trial attorney assigned to this matter, I advised that the time period he suggested for the interviews was not convenient due to an ACA inspection scheduled to occur in the same time period. I advised Mr. Daly, "if after reviewing the ACA monitoring visit report you still have an interest in interviews with residents of Rader, we will be able to discuss residual concerns you may have at that point and determine what specific procedures would be appropriate for the taking of additional interviews by your agency." I sent a copy of the ACA report to Mr. Daly. If Mr. Daly had residual concerns, they were not communicated to me and no request to conduct interviews was received. I am attaching copies of two letters received from ACA concerning this inspection.

The following is a response to the specific headings contained in Mr. Acosta's letter and a summary of the evidence the State will present at trial:

BACKGROUND

The L.E. Rader Center is an ACA-accredited facility, operated by the Office of Juvenile Affairs (OJA). All facilities operated by the Office of Juvenile Affairs are mandated, by State law, to be accredited by the American Correctional Association. *See* 10 O.S. 2001, 7302.6. The L.E. Rader Center also continues to operate under policies and conditions established in prior juvenile litigation, *Terry D., et al. v. L. E. Rader Center*, which, *inter alia*, requires all facilities operated by OJA to comply with ACA standards. The OJA Advocate General's Office is mandated to investigate all grievances of juveniles. *See* 10 O.S. 2001, 7302-3.2. The OJA Advocate General is required to report all allegations of abuse and neglect to a separate agency, the Oklahoma Department of Human Services (DHS). *See* 10 O.S. 2001, 7302-3.2. Additionally, OJA's Office of Public Integrity monitors the juvenile institutions to insure compliance with Federal and State laws, OJA Policies and Procedures and ACA Policy and Procedures. *See* Rule OAC 377:3-13-1. Two independent agencies, the Oklahoma Department of Human Services and the Oklahoma Commission on Children and Youth (OCCY), investigate all abuse complaints at the facility. *See* 10 O.S. 2001, 7004-3.4 and

10 O.S. 2001, 600 *et seq.*, respectively. Juvenile facilities are licensed by a separate agency, the Oklahoma Department of Human Services. *See* 10 O.S. 2001, 401 *et seq.* Staff-to-resident ratios are set by the Department of Human Services. Three Assistant Attorneys General are assigned to the Office of Juvenile Affairs to assist it with meeting State standards which exceed the minimal constitutional standards enforced by your agency. Although isolated incidents may occur, the State's system of checks and balances is designed to prevent a pattern and practice of civil rights deprivations from occurring. Attached hereto is a list of oversight entities.

The response to the Department of Justice findings, which follows, reflects the outcome of applicable investigations by various entities. Under Oklahoma law and formal rules promulgated by State agencies, referrals from the Office of Juvenile Affairs regarding abuse, neglect, or caretaker misconduct are processed for appropriate disposition by the Department of Human Services (DHS). *See* DHS Rule OAC 340:2-3-35. Formal investigations conducted by DHS are performed by DHS' Office of Client Advocacy (OCA). The findings of OCA are forwarded to OJA for response. In addition, the findings of OCA may be appealed to the Grievance and Abuse Review Committee (GARC). GARC conducts a *de novo* paper review of the alleged incident and issues a report of its findings, which are submitted to the Director of the Department of Human Services. The Director of DHS has final review authority over formal OCA investigations. Many of the incidents in the Department of Justice's letter alleged to have occurred at the L.E. Rader Center were formally investigated by DHS and some were appealed to GARC. The outcomes are provided in our response.

A referral to DHS may also be assigned by OCA to the facility for an internal investigation. These are called "Caretaker Conduct Reviews." Our response includes these types of investigations and the outcomes of these investigations. Finally, a referral may be dispositioned by OCA as a "Refer to Administration." A referral disposed in this manner means it is not within the purview of OCA, DHS, or another State agency, but is relevant to the facility's operations. No response from the facility is required in these situations. Some of the incidents cited by the Department of Justice were referred to administration and did not require a response and are so indicated in our response.

As the Office of Juvenile Affairs' youth population became older (with the inclusion of youthful offenders), and in some respects more violent, it became difficult to find appropriate mental health treatment for this population which frequently included serious, self-harming youth. In response to the shrinking pool of private, mental health providers, the Office of Juvenile Affairs developed its own Mental Health Stabilization Unit at Rader. The Unit was modeled after that established in Texas at the Corsicana Juvenile Facility following visits by a team of OJA professionals and legal staff and after in-depth consultation with Texas professional and administrative staff. Procedures were developed for admission and retention and a program implemented to stabilize the functioning of this population. The Mental Health Stabilization Unit began receiving formal admissions in August 2003. Since the establishment of the Unit, inpatient

mental health commitments of institutionalized youth have dropped significantly. Most admittees are appropriately stabilized and returned to the general population. The Office of Juvenile Affairs, having identified a need in the system, addressed it responsibly and professionally. The Legislature, supporting the Agency's goal of providing professional and responsive treatment for youth with serious mental health issues, appropriated additional funding for the Mental Health Stabilization Unit. The Office of Juvenile Affairs continues to improve operations of this Unit and has recently contracted with the Department of Mental Health and Substance Abuse Services for the services of its chief child psychiatrist who regularly provides on-site care and consultation with Mental Health Stabilization Unit residents and treatment staff.

II. FINDINGS

A.1. Sexual Relationship Between Staff and Youth

Allegation: On May 31, 2004, it is alleged that a female staff member permitted a youth to carry her into his room where the youth and others fondled her. It was also alleged that the female staff member previously spoke in a sexual manner with the youth and permitted them to touch her in inappropriate ways.

Response: The DHS Office of Client Advocacy directed the facility to conduct an investigation. The investigation did not confirm the allegation of caretaker misconduct. No disciplinary action was necessary.

Allegation: In the fall of 2003, it is alleged that a female staff member and a male youth engaged in a sexual relationship and that Rader staff found correspondence between the two that confirmed the relationship.

Response: The DHS Office of Client Advocacy (OCA) declined to investigate and referred the allegation back to Rader Administration. The Office of Public Integrity (OPI) conducted an investigation. OPI confirmed sexual misconduct. The staff member's employment was terminated.

Allegation: In September 2003, a female staff member engaged in a sexual relationship with a male youth classified as a sex offender. The Office of Client Advocacy confirmed sexual abuse by the staff member.

Response: The DHS Office of Client Advocacy confirmed sexual abuse by staff. While there is no evidence as to any physical sexual abuse, the staff member dressed provocatively and had a sexualized personal relationship with the resident. The staff member's employment was terminated.

Allegation: Between July 2003 and October 2003, a female staff member and a male youth engaged in inappropriate sexual relations.

Response: The DHS Office of Client Advocacy confirmed the allegation of sexual abuse by staff. The investigation found that the staff member engaged in a pattern of grooming behaviors with the resident and wrote him a sexually explicit letter. The staff member resigned in lieu of termination.

Allegation: Between September 2002 and February 2003, a female staff member and a male youth engaged in a sexual relationship.

Response: The DHS Office of Client Advocacy confirmed the allegation of sexual abuse by staff. The investigation found staff to have a sexualized relationship with the resident and to have shown him preferential treatment. The staff member's employment was terminated.

In summary, all allegations of abuse were investigated, and appropriate disciplinary actions were taken when warranted.

A.2. Sexual Relationships Between Youth

Allegation: Two youths engaged in mutual masturbation on April 3 and 4, 2004.

Response: The DHS Office of Client Advocacy confirmed the allegation of caretaker misconduct. The investigation found that staff failed to provide adequate supervision and the residents engaged in inappropriate sexual behavior. Staff received an oral reprimand together with a corrective action plan.

Allegation: On January 29, 2004, an 18-year-old male engaged in anal sex with a 14-year-old male in the restroom of the gym while two staff members supervised 13 other youth.

Response: The DHS Office of Client Advocacy did not confirm the allegation of neglect by staff. No disciplinary action was required.

Allegation: Two female youth engaged in sexual activity in their dormitory on at least one occasion.

Response: The DHS Office of Client Advocacy confirmed the allegation of caretaker misconduct. The investigation found that staff failed to provide adequate supervision and the residents engaged in inappropriate sexual behavior. Staff received a three-day suspension without pay.

Allegation: Between May 2003 and June 2003, two youth engaged in a sexual relationship while housed in a sex offender unit.

Response: The DHS Office of Client Advocacy confirmed an allegation of neglect. The investigation found that staff failed to provide adequate supervision and the residents engaged in inappropriate sexual behavior. Staff received a three-day suspension without pay.

Allegation: On January 26, 2003, two youths, classified as sex offenders, left the day room and entered one of the bathrooms where they engaged in anal and oral sex.

Response: The DHS Office of Client Advocacy directed the facility to complete an investigation and submit a Caretaker Conduct Review report. The investigation did not confirm the allegation of caretaker misconduct. No disciplinary action was required.

All incidents in this subsection were investigated either by the Office of Client Advocacy or the facility and disciplinary action was taken when caretaker misconduct or neglect was confirmed.

B. Youth on Youth Violence

Allegation: On June 18, 2004, a newspaper reported a brawl between youth who were members of rival gangs.

Response: The DHS Office of Client Advocacy directed the facility to complete an investigation and submit a Caretaker Conduct Review report. The investigation confirmed caretaker misconduct for failure to follow procedures. The staff members received an oral reprimand together with a corrective action plan.

Allegation: On May 16, 2004, two youths involved in an argument at the gym were sent back to the dorm unescorted. When they arrived at the dorm, one youth attacked the other. A staff member at the dorm refused to break up the fight, ordering other juveniles to intervene.

Response: The DHS Office of Client Advocacy directed the facility to complete an investigation and submit a Caretaker Conduct Review report. The investigation did not confirm caretaker misconduct on staff. No disciplinary action was required.

Allegation: On May 14, 2004, two youths fought for several minutes in one of the youth's bedroom until another youth broke up the fight.

Response: The DHS Office of Client Advocacy directed the facility to complete an investigation and submit a Caretaker Conduct Review report. The investigation did not confirm caretaker misconduct on staff. No disciplinary action was required.

Allegation: On May 8, 2004, two youths entered a bathroom and began to fight. A staff member was not aware of the fight until another youth advised the staff member that one of the youths was in the bathroom with his nose bleeding.

Response: The DHS Office of Client Advocacy confirmed the allegation of caretaker misconduct. The investigation found the staff failed to provide adequate supervision and the residents were able to engage in a physical altercation. The staff member resigned in lieu of termination.

Allegation: On May 7, 2004, one youth approached another from behind, then choked and slammed him to the ground. The youth claims there was staff in the room but that they did not intervene.

Response: The DHS Office of Client Advocacy directed the facility to complete an investigation and submit a Caretaker Conduct Review report. The investigation did not confirm caretaker misconduct. No disciplinary action was required.

Allegation: On April 29, 2004, a series of assaults occurred in the Mental Health Stabilization Unit.

Response: Documentation from the Mental Health Stabilization Unit logbook reflects minor altercations between the residents. These do not rise to the level of required reporting. As part of the ACA audit eight residents in the Mental Health Stabilization Unit were interviewed and reported they were well treated and felt safe in the unit.

Allegation: On January 17, 2004, a youth claims that three youths entered his room and assaulted him. Several minutes passed before staff realized what was happening and responded to the incident.

Response: The DHS Office of Client Advocacy directed the facility to complete an investigation and submit a Caretaker Conduct Review report. The investigation did not confirm caretaker misconduct. No disciplinary action was required.

Allegation: On November 24, 2003, one youth assaulted another in the shower due to inadequate staff supervision.

Response: The DHS Office of Client Advocacy did not confirm the allegation of abuse. No disciplinary action was required.

Allegation: On July 30, 2003, one youth assaulted another youth. One staff member intervened but the other staff member allowed other youths to kick a youth and staff member as they lay on the floor.

Response: The DHS Office of Client Advocacy confirmed the allegation of neglect with injury. The investigation found that staff failed to provide assistance to another staff member during an altercation with the resident. The resident suffered injuries as a result. The staff member received a three-day suspension without pay, together with a corrective action plan.

Allegation: On April 16, 2004, one youth assaulted another youth. A staff member who was only a few feet away failed to intervene.

Response: The DHS Office of Client Advocacy confirmed the allegation of neglect with injury. The investigation found that staff failed to provide adequate supervision when one resident assaulted another resident. Staff resigned in lieu of termination.

Allegation: On February 14, 2004, a staff member encouraged two youths to settle their differences by going to their cells and fighting. The staff member stood beside the locked cell door as they fought and did not intervene.

Response: The DHS Office of Client Advocacy confirmed the allegation of abuse with injury. The investigation found that staff failed to provide adequate supervision when one resident assaulted another resident. The staff members resigned prior to the conclusion of the investigation.

Contraband

Allegation: On September 19, 2004, a juvenile assaulted staff with a 3 - 4 foot long piece of stainless steel.

Response: The resident received a major rule violation for threats to do harm, assault on staff and peer and aggravated assault. The resident was transported to the county jail.

Allegation: In May 2004, security found a metal rod hidden in a mattress.

Response: The resident received a major rule violation for possession of contraband.

Allegation: In October 2003, staff searched the girls' unit and found drugs and drug paraphernalia.

Response: The resident received a major rule violation for possession of contraband. Upon discovery of the contraband, staff recommended a unit/campus shutdown and campus search.

Allegation: In June 2003, a search revealed batteries and bleach in a juvenile's room after he ingested psychotropic medication belonging to another youth.

Response: The resident received a major rule violation for ingesting another resident's medication.

Allegation: In May 2003, three youths tested positive for marijuana.

Response: The DHS Office of Client Advocacy did not confirm neglect by staff. The residents received a major rule violation for possession of contraband and for testing positive on a urinalysis.

Allegation: In April 2003, a juvenile was found with razorblade.

Response: One resident advised staff that another resident had taken a razor blade during class and hidden it in the air vent. Upon the search of the resident's room, contraband was discovered. It could not be determined which resident placed the contraband in the air vent, so no resident received a sanction.

Allegation: On January 6, 2003, a male youth's room was searched and the following was discovered: money, rolling papers, cigarettes, a lighter, pornography, materials used in making tattoos and pills.

Response: The resident received a major rule violation for possession of contraband.

OJA's policy which sets the parameters for searches is attached. Possession of contraband is a major rule violation.

C. Self-Injurious and Suicidal Behavior

Suicide

Allegation: On March 21, 2004, a youth cut his wrist with the metal from a pencil eraser and pulled out sutures. The youth also attempted to strangle himself with a rope made from a towel and his shirt.

Response: The DHS Office of Client Advocacy did not confirm neglect by staff. No disciplinary action was required.

Allegation: February 24, 2004, a youth went to his room and attempted to hang himself with his belt. Staff was not aware of the attempt until the youth yelled out in pain after falling to the floor.

Response: The initial report from the DHS Office of Client Advocacy confirmed caretaker misconduct with injury. The facility appealed the finding to the Grievance and Abuse Review Committee (GARC). GARC reversed the finding stating there was insufficient evidence to support the original finding.

Allegation: On August 19, 2003, a youth in the Mental Health Stabilization Unit cut himself and was placed on suicide watch. The youth went to his room without supervision, fashioned strips of his shirt into a noose, and placed it around his neck. Staff found him on the floor of his room with red marks around his neck.

Response: The DHS Office of Client Advocacy did not confirm the allegation of neglect by staff. No disciplinary action was required.

Allegation: On April 10, 2003, staff discovered a youth attempting suicide by tying a string around his neck.

Response: The resident received a major rule violation for attempted suicide.

Allegation: On January 16, 2003, a youth cut his wrists with a piece of metal. He was placed in the day room for close observation. One hour later he attempted to strangle himself by tying a pillowcase around his neck.

Response: Due to the resident's being placed on close observation, staff was able to intervene immediately when the resident placed a pillowcase around his neck.

To deter this behavior suicide attempts are considered a major rule violation.

Self-Injurious Behavior

Allegation: On May 28, 2004, a youth on close observation went to an unauthorized area and struck a window with his fist.

Response: The DHS Office of Client Advocacy directed the facility to complete an investigation and submit a Caretaker Conduct Review report. The investigation ruled out caretaker misconduct. No disciplinary action was required.

Allegation: On May 5, 2004, a youth inserted a two-inch section of a paperclip into his left forearm. Staff did not realize this until three days later.

Response: The DHS Office of Client Advocacy directed the facility to complete an investigation and submit a Caretaker Conduct Review report. The investigation did not confirm caretaker misconduct. No disciplinary action required.

D. Failure to Safely Distribute Psychotropic Medication

Allegation: In April 2004, staff found a youth in his room sitting in a chair. He was non-responsive to verbal commands. Documents indicate the youth had consumed seven pills.

Response: Incident reports reflect the resident received immediate medical attention upon discovery that he had ingested seven (7) pills.

Allegation: In September 2003, a youth provided two pills of psychotropic medication and two pills of an anti-depressant medication to two other youths who crushed and snorted the pills.

Response: The DHS Office of Client Advocacy directed the facility to complete an investigation and submit a Caretaker Conduct Review report. The investigation did not confirm caretaker misconduct. No disciplinary action was required.

Allegation: On August 11, 2003, a male youth swallowed eight (8) pills during medication distribution. Over a two-week period he "cheeked" some of his medication and received prescription medication from another youth and hid it in his room.

Response: The DHS Office of Client Advocacy did not confirm the allegation of neglect by staff. No disciplinary action was required.

Allegation: On July 20, 2003, a male youth provided thirteen pills to three other youths.

Response: The DHS Office of Client Advocacy did not confirm the allegation of neglect by staff. No disciplinary action was required.

Allegation: On June 17, 2003, a male youth took psychotropic medication meant for another juvenile.

Response: The resident received a major rule violation for ingesting another resident's medication.

Allegation: On May 3, 2003, a nurse gave a youth the wrong medication during pill distribution.

Response: While the allegation does rise to the level of reporting requirements, no documentation can be found reflecting the incident was reported. Uniform reporting policies have been implemented to avoid a failure to report.

Cheeking of medication and possession of contraband are considered major rule violations and youth are sanctioned when it is established they have engaged in this type of conduct..

E. Excessive Force by Staff

Four examples of excessive force by staff are cited in Mr. Acosta's letter.

Allegation: On March 15, 2004, a male youth tried to push past staff who pushed him to the ground on his back.

Response: The initial report from the DHS Office of Client Advocacy confirmed the allegation of caretaker misconduct by staff. The facility appealed the finding to the Grievance and

Abuse Review Committee (GARC). GARC reversed the findings, stating there was insufficient evidence to support the original finding.

Allegation: On December 12, 2003, a female staff member and male resident argued over the placement of a bed in a room. The staff member called the youth a bad-ass bastard and slapped a cup out of his hands. In the process, she struck the youth in the face. The staff member had to be restrained by other staff members. The staff member cursed and verbally threatened to harm the juvenile.

Response: The DHS Office of Client Advocacy confirmed the allegation of abuse by staff. The investigation found the staff member used excessive and unauthorized use of force when she slapped a cup of ice from the resident's hand and scratched his eye. The staff member resigned in lieu of termination.

Allegation: On November 9, 2003, a staff member grabbed a youth and threw him to the floor after he refused to obey a direct order.

Response: The DHS Office of Client Advocacy confirmed the allegation of caretaker misconduct by staff. The investigation found that staff used excessive and unauthorized use of force when he pulled the resident down from on top of the stainless steel table by the resident's arm. Staff received an oral reprimand.

Allegation: On May 10, 2003, a youth repeatedly requested a snack from a staff member. The staff member became angry and lunged at the youth. Staff picked up the youth and attempted to throw him over his shoulder. Another staff member responded to the altercation and attempted to strike the youth with his forearm. Security arrived and the staff members pushed security away and attempted to continue the fight.

Response: The DHS Office of Client Advocacy confirmed the allegation of abuse by staff. The investigation found the staff members used excessive and unauthorized use of force during a restraint after staff intentionally escalated the situation. One staff member's employment was terminated, and one staff member resigned in lieu of termination.

III. REMEDIAL MEASURES

A boilerplate list of non-specific remedial measures is listed with no discussion as to how the cited incidents establish the alleged deficiencies exist or what actions the state needs to take to comply with the remedial measures.

In summary, the evidence shows that the State of Oklahoma is not subjecting juveniles at the L.E. Rader Center to egregious or flagrant conditions or depriving them of their rights under the Constitution or laws of the United States. The isolated incidents cited in Mr. Acosta's letter do not establish a pattern and practice of civil rights violations. The State of Oklahoma seeks to provide more than the constitutionally minimum care to the juveniles confined in its juvenile facilities. In an effort to provide better services, the L.E. Rader Center has established a Mental Health Stabilization Unit. In a footnote to Mr. Acosta's letter, it is intimated that there are no policies and procedures that govern the Mental Health Stabilization Unit. That is not accurate, and a copy of the Policies and Procedures that were in effect during the period in question and which govern the operation of that unit are enclosed with this letter. In addition, the Oklahoma Legislature has appropriated money for a new security fence at the facility which should discourage escape attempts. The facility has also employed the services of a gang expert to provide training in the area of juvenile gangs.

If you have specific examples of how the State of Oklahoma can improve the care that juveniles residing in the L.E. Rader Center receive, we are willing to meet with you and discuss them. Generalities such as those listed in your proposed remedial measures are of no assistance. Title 42 U.S.C., §1997b(a)(2)(A) states that "the Attorney General is to consult with the State regarding financial aid and technical assistance available from the United States that he believes may assist in the correction of such conditions and pattern or practice of resistance." Please advise what specific financial aid and technical assistance is available from the United States.

The State of Oklahoma is willing to meet with the Attorney General, or his representatives, at a mutually agreeable and convenient time and place to discuss the issues raised in Mr. Acosta's letter. If you want to schedule such a meeting, I will be glad to contact the appropriate State officials and have them present at the meeting.

I look forward to hearing from you.

Sincerely,

E. Clyde Kirk

E. Clyde Kirk
Assistant Attorney General

Enclosures: List of Oversight Entities
Mental Health Stabilization Unit Policies and Procedures
OJA Policy for Searches
ACA letters dated 2-3-2005 and 4-1-2005

cc: Drew Edmondson
Attorney General

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Office of the Governor

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Executive Director
Office of Juvenile Affairs

Susan Noland
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