U.S. Department of Justice
Civil Rights Division

Assistant Attorney General
950 Pennsylvania Ave, NW - RFK
Washington, DC 20530

January 18, 2011

BY FIRST CLASS MAIL

The Honorable Michel Claudet
President, Terrebonne Parish
8026 Main Street, Suite 700
Houma, LA 70360

Re: Terrebonne Parish Juvenile Detention Center, Houma, Louisiana

Dear Mr. Claudet:

I write to report the findings of the Civil Rights Division's investigation of conditions at the Terrebonne Parish Juvenile Detention Center ("Terrebonne" or "the Facility"). On November 19, 2009, we notified Parish officials of our intent to conduct an investigation of Terrebonne pursuant to the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141 ("Section 14141"). Section 14141 gives 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 youth in juvenile justice institutions.

Summary of Findings

The youth confined to Terrebonne are subjected to conditions that place them at serious risk of avoidable harm in violation of their rights protected by the Constitution of the United States. During our investigation, we received a significant number of credible reports of sexual and physical misconduct by staff members on youth within their custody. The allegations exposed wide-spread and systemic abuses and revealed a lack of accountability and controls that would have prevented harm to the young people confined there.

Allegations of sexual misconduct have led to criminal charges against seven staff members. Our findings are not limited to the conduct charged in the criminal cases, but include numerous additional accounts. These incidents are compounded by a lack of systems in place to identify and correct misconduct.

In addition to sexual misconduct, there is a pervasive atmosphere of excessive force and violence. We found:

- Physical restraints, including handcuffing and a restraint chair, are routinely used when verbal or non-physical methods would have been adequate;
- The inappropriate and dangerous use of chemical agents;
- Excessive use of isolation as punishment or for control;
- Suicidal behavior six times the national average and an inadequate suicide prevention program; and
- High levels of fighting and assaults between youth.

These conditions are the result of, and allowed to continue to exist because generally accepted juvenile justice standards are not followed. We found that staff did not receive minimally adequate training, and that existing policies and procedures are inadequate to ensure: that minimally necessary force is used to control youth; that chemicals are used safely; or that youth are protected from sexual or physical abuse. In addition, we found that the facility lacks adequate staff and that the staffing pattern places youth at risk of harm because of fatigue, reduced accountability, overreliance on seclusion, and inadequate supervision.

Significantly, we found limited mechanisms to provide accountability. During our inspections we uncovered staff members who lied about performing room checks. This information would not have been discovered but for our efforts. In addition, we found that child abuse allegations are not reported to state officials as required by law; the facility fails to collect data that would permit managers to identify and address problems; there is inadequate supervision of line staff; and no meaningful quality assurance program exists.

The failure to meet generally accepted juvenile justice standards in the face of severe problems in the facility violates the Fourteenth Amendment's mandate that youth in state custody be protected from harm. In this letter we provide additional recommendations that are minimally necessary to bring the facility into compliance with the Constitution.

Investigation

On March 22-25, 2010, we conducted on-site inspections at Terrebonne with expert consultants in juvenile justice administration and protection from harm. We interviewed Facility management personnel, direct care and administrative staff, and youth. Before, during, and after our visits, we reviewed an extensive number of documents, including policies and procedures, incident reports, investigative reports, grievances from youth, staff personnel files, unit logs, orientation materials, staff training materials, and school records. In keeping with our pledge of transparency and to provide technical assistance where appropriate, we conveyed our preliminary findings to Terrebonne and Terrebonne Parish officials at the close of our on-site visits. We followed up with a letter to the Parish on April 22, 2010 outlining some of our most pressing concerns.[1]

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[1] In our letter, we expressed serious concern that overnight rooms checks were not being consistently performed, and that staff routinely appeared to be falsifying room check documentation. In addition, we expressed concern that overnight shift staff were not being adequately supervised and were not being held accountable for complying with Terrebonne policies and procedures.

We commend the staff at Terrebonne for their helpful and professional conduct throughout the course of the investigation. We received full cooperation with our investigation and appreciate the Parish's receptiveness to our consultants' on-site recommendations. Also, we appreciate comments made by Ralph Mitchell, the Director of the Terrebonne Parish Department of Public Safety, indicating that he had become aware of some of the problems we identified, and had begun formulating remedies to address some of our most serious concerns.

In addition, we appreciate the thorough cooperation provided by Facility Director Jason Hutchinson. Director Hutchinson brings a number of strengths to the role of facility superintendent -- he is a bright, caring, dedicated, and committed person who has brought about several innovations in education and programming that affirm his commitment to the best interest of detained youth. He is appropriately educated, holding a bachelor's degree in psychology and a master's degree in special education. Director Hutchinson has experience working with troubled youth in the public schools and educational programming for adults in jail. The Director was highly receptive to our observations and has reported to us that he has implemented a number of remedial measures in response to our April 22, 2010 letter. In particular, on May 20, 2010 we were advised by counsel for the Parish that the Director has taken steps to ensure that overnight room checks are performed in a timely manner, and that overnight shift staff are now subject to periodic surprise visits by external law enforcement personnel.

We now write to advise you of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to address the deficiencies we have identified. As described more fully below, we conclude that certain conditions at Terrebonne violate the constitutional rights of the youth.

I. BACKGROUND

Terrebonne is a secure juvenile detention facility opened on September 1, 1998 and located in Houma, Louisiana. The Facility's mission is to "provide short-term care in the secured custody of juveniles who are accused, adjudicated pending court action, awaiting transfer to another facility, and who cannot be served in an open setting."[2] Terrebonne also served as one of three regional placement centers in Louisiana for adjudicated female youth pursuant to a per diem contract between Terrebonne Parish and the State. In May 2009, however, the State removed its contracted population from the Facility, and only the detention and pending placement populations remain.

One of the published goals of Terrebonne is to house "the juveniles in a safe and humane environment, maintaining the level of security necessary to prevent escape and assure that the juveniles live free of fear from assault or intimidation by staff or other juveniles." Terrebonne has a capacity to hold 60 juveniles, including 40 males and 20 females. On February 1, 2010, the Facility housed a total population of 40 youth, and during the period of review, remained below

[2] http://www.tpcg.org/view.php?f=juvenile_detention.

operational capacity. Between its 1998 opening and July 31, 2007 (the most recent period for which published figures are available), the Facility has processed over 7,000 youth.[3]

II. LEGAL STANDARDS

Section 14141 authorizes the Department of Justice to seek a remedy for a pattern or practice of conduct that violates the constitutional or federal statutory rights of youth in juvenile justice institutions. 42 U.S.C. § 14141. Youth detained at Terrebonne are protected by the Fourteenth Amendment and have a substantive due process right to reasonably safe conditions of confinement and freedom from unreasonable bodily restraints. Youngberg v. Romeo, 457 U.S. 307, 316 (1982) ("If it is cruel and unusual punishment to hold convicted criminals in unsafe conditions, it must be unconstitutional to confine the involuntarily detained - who may not be punished at all - in unsafe conditions."). The Fourteenth Amendment, rather than the Eighth Amendment applies because the youth are held for detention or rehabilitation, not punishment. [4] The purpose of the Louisiana youth delinquency statute is to "accord due process to each child who is accused of having committed a delinquent act... and to secure for him care as nearly as possible equivalent to that which the parents should have given him."[5]

To determine whether the Fourteenth Amendment was violated, a balancing test must be applied: "It is necessary to balance 'the liberty of the individual' and 'the demands of an organized society.'" Youngberg at 320 citing Poe v. Ullman, 367 U.S. 497, 542 (1961) (Harlan, J., dissenting). The Youngberg Court went on to hold that "If there is to be any uniformity in protecting these interests, this balancing cannot be left to the unguided discretion of a judge or jury." Id. at 321. Instead, the Court held that there was a constitutional violation if the detaining official substantially departed from generally accepted professional standards, and that departure endangers youth in their care. See id. at 314.

As a general matter, the Supreme Court has held that corrections officials must take reasonable steps to guarantee detainees' safety and provide "humane conditions" of confinement. Farmer v. Brennan, 511 U.S. 825, 832 (1994); Scott v. Moore, 85 F.3d 230, 235 (5th Cir. 1996) (holding that a municipality assumed a constitutional obligation to provide pre-trial detainees with minimal levels of safety and security); Hare v. City of Corinth, 74 F.3d 633, 639 (5th Cir.) (en banc) (recognizing a duty to provide detainees with basic human needs including protection from harm). In addition, an official's failure to maintain adequate policies, procedures, and

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[3] Id.

[4] In Ingraham v. Wright, the Supreme Court rejected application of the Eighth Amendment deliberative indifference standard in a non-criminal context. 430 U.S. 651, 669 n.37 (1977) ("Eighth Amendment scrutiny is appropriate only after the State has complied with the constitutional guarantees traditionally associated with criminal prosecutions."). In addition, the Court held that the Due Process Clause of the Fourteenth Amendment was the proper constitutional gauge to determine the rights of adults detained by a state, but not yet convicted of any crime. Bell v. Wolfish, 441 U.S. 520 (1979). See also, Scott v. Moore, 85 F.3d 230, 235 (5th Cir. 1996). At a minimum, youth should be accorded the same constitutional protections.

[5] La. Child. Code Ann. art. 801 (2010).

practices for the prevention of suicides may violate a detainee's due process rights. Silva v. Donley County, 32 F.3d 566, 1994 WL 442404, *5-7 (5th Cir. 1994) (unpublished) (holding sheriff's failure to establish suicide detection and prevention training for jail personnel, condoning de facto policy of sporadic cell checks, and absence of a policy for observing "at-risk" detainees may rise to deliberate indifference to known risk of suicide in detention settings).

Additionally, juvenile detainees have a constitutional right to be free from sexual assault and forced sexual contact by correctional staff. See, e.g., Spencer v. Doe, 139 F.3d 107, 112 (2d Cir. 1998) (noting that juvenile detainee had the right to be protected from sexual molestation under the Fourteenth Amendment); Ware v. Jackson County, 150 F.3d 873, 884-85 (8th Cir. 1998) (sexual assault of adult inmate may violate Eighth Amendment); Barney v. Pulsipher, 143 F.3d 1299, 1310 (10th Cir. 1998) (forced oral sex and sexual assault of adult prisoners are "sufficiently serious to constitute a violation under the Eighth Amendment"). Sexual assaults by staff, including rape, coerced sodomy, or touching of female prisoners' breasts and genitalia, are simply not part of the penalty that juvenile detainees pay for their offenses against society. See Farmer v. Brennan, at 834.

Confined youth have a constitutional right of freedom from unreasonable bodily restraints. Youngberg v. Romeo, at 320. The routine improper use of an isolation unit in a state facility can constitute cruel and unusual punishment. Morgan v. Sproat, 432 F. Supp 1130 (S.D. Miss. 1977). In Morgan, youth were placed on the highly restrictive unit for a variety of disciplinary offenses, including some as minor as "being disrespectful to staff members, stealing, and behaving inadequately...". Id. at 1129. The average length of confinement on the unit was 11 days. After considering extensive expert testimony in other cases, the court severely restricted the conditions under which the facility could place youth in such a unit:

> The defendants will therefore be enjoined from using the isolation unit as an isolation unit, except under the following limited conditions which are necessary to insure that placement therein will not do any emotional or psychological harm to the students: students may not be placed in the isolation unit except where there is substantial evidence that they constitute an immediate threat to the physical well-being of themselves or others; confinement may not exceed 24 hours and must be approved within one hour of the confinement by the Superintendent, one of the Assistant Superintendents, the Chief Counselor or a staff psychologist; students in the isolation unit must be visited at least once every three hours during the day by the Chief Counselor, the students' own counselor or a licensed psychologist; the cells in the isolation unit must be provided with transparent windows, lights, mattresses, blankets, sheets, pillows, small tables for reading, chairs, soap and towels; unless a contrary program is indicated in an individual case by a licensed psychologist, students placed in the isolation unit must be permitted to sleep a reasonable time during the day, to have reading materials, to send and receive mail, and to have visitors; the students must receive daily at least an hour's physical exercise outside of the isolation unit or in the gym; and they must be allowed to eat their meals outside of their cells. Id. at 1140.

Finally, conditions of confinement claims may be based not only upon existing physical harm to youth, but also on conditions that threaten to cause future harm. Helling v. McKinney,

509 U.S. 25 (1993) (stating "it would be odd to deny relief to detainees who plainly proved an unsafe, life-threatening condition in their facility on the ground that nothing yet had happened to them."). In Helling, the court recognized various circuit courts holding that "a detainee need not wait until he is actually assaulted before obtaining relief" and that the Constitution "protects against sufficiently imminent dangers..." Id., at 33-35 (internal citations omitted). See also, Herman v. Holiday, 238 F.3d 660 (5th Cir. 2001) (recognizing Helling standard); Hoeing v. Collins, 95 F.3d 53 (5th Cir. 1996) (unpublished); Gates v. Collier, 501 F.2d 1291, 1308-10 (5th Cir. 1974) (holding that failure to provide adequate systems to protect inmates against future harm including physical assaults and abuse constituted cruel and unusual punishment).

III. FINDINGS

We find that Terrebonne fails to adequately protect youth in its care from harm and serious threat of harm by staff, other youth and from self-harm.

A. The Facility fails to adequately protect youth from harm by detention staff.

In 2009, direct care staff members (including two supervisors) were indicted or charged with a total of 21 counts of custodial sexual misconduct or related crimes involving female youth under their supervision. These crimes include molestation, indecent behavior, criminal malfeasance, and obstruction of justice. While the charged staff members have not yet been adjudicated in a criminal court,[6] Parish and Facility officials have not disputed the substance of the charges, and have taken some corrective action to prevent a recurrence of the conduct alleged. The charged staff members have all been removed or have resigned from their posts. A summary of the most serious charges follow.

On June 24, 2009, a Louisiana grand jury returned an eight-count indictment against Supervisor 1[7], a male Terrebonne correctional supervisor in charge of the night shift, alleging that Supervisor 1 engaged in unlawful lewd behavior and sexual conduct with four detained female youth, ages 15 or 16, between April 29, 2008 and April 28, 2009.

Three weeks later, on July 13, 2009, the grand jury returned a four-count indictment against Staff 1, a male Terrebonne correctional officer, alleging that Staff 1 engaged in unlawful lewd behavior and sexual conduct with two detained female youth, ages 15 and 16.

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[6] Four of the accused staff are scheduled for trial in February 2011, with the remaining staff trial dates to occur sometime afterwards.

[7] Because individuals who have been charged but not yet adjudicated in a criminal court are presumed innocent, we are not using the names of the accused staff.

In addition to the grand jury indictments against Supervisor 1 and Staff 1, the Terrebonne Parish District Attorney brought charges directly (bypassing the grand jury system) against four additional Terrebonne staff related to custodial sexual misconduct at the Facility.[8]

* * *

Whether or not each of the charged staff are ultimately adjudicated guilty in a criminal court, we examined whether there are adequate systems and structures in place at Terrebonne to minimize the risk of future harm to youth. Helling, 509 U.S. at 33-35. We find, among other things, that youth are not adequately protected from harm by staff. Specifically, we find that staff are not adequately supervised; that use of force policies, procedures, and practices are inadequate; that there are inadequate numbers of direct care staff to ensure the safety of youth; that there are inadequate systems for reporting allegations of child abuse; and that the Facility fails to provide appropriate training on the prevention of custodial sexual misconduct. In each of these areas, we find that Terrebonne substantially departs from generally accepted professional standards in juvenile detention in a manner that endangers youth, and thus violates the youths' constitutional rights to reasonably safe conditions of confinement and freedom from unreasonable bodily restraint. Youngberg, 457 U.S. at 324.[9]

1. Staff Accountability

Since February 2009, a total of 15 incidents of staff misconduct were investigated at the facility level. The 15 incidents were all investigated and staff were held accountable for their failure to follow required procedures. Staff received letters from the Director that discussed the procedures violated and why they were important to the effort to protect youth from harm and suggested appropriate ways of handling the situation, should it arise again in the future.

While these examples represent efforts on the part of Facility administrators and supervisors to enforce some Facility procedures and hold staff accountable for their failures to follow certain Facility procedures, during the week of our visit, we became aware of several other instances in which staff routinely violate policy and procedure and yet were not held

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[8] These charges alleged, among other things, that Staff 2 engaged in unlawful custodial sexual misconduct with a female youth, age 14-15, over a ten month period ending in March 2009; and that Supervisor 2 engaged in unlawful custodial sexual misconduct with a female youth, age 15-16, over a six month period ending in March 2009. Both Staff 2 and Supervisor 2 are male.

[9] Even applying the more lenient adult corrections deliberate indifference standard, we find that Parish officials disregarded known substantial risks of serious harm to youth at the Facility, and thus acted with deliberate indifference to those risks in violation of youths' constitutional rights. See Helling, 509 U.S. at 33-35. For example, at least as early as June 2009, officials were aware of serious criminal allegations regarding custodial sexual misconduct at the Facility, but had not taken necessary remedial steps to eliminate this known danger. Similarly, at least as early as October 2009, officials were aware of the high rate of suicidal behavior at the Facility, but had not taken necessary remedial steps to ameliorate this known risk.

accountable for their behavior. While certain supervisors may have been aware of the staffs' failures in these areas, no formal investigation or documentation regarding employee discipline was provided. As discussed throughout this letter, this lack of staff accountability has led to a blatant disregard for the performance of job functions essential to keeping youth reasonably safe in a juvenile detention facility. Youngberg, 457 U.S. at 324. See also, Gates, 501 F.2d at 1308-10 (holding failure to adequately supervise inmates unconstitutional). These situations included:

- Failing to make 15-minute confinement checks (violates Policy #17.2 "Minor Violations and Their Resolutions," "During room restriction staff contact will be made every 15 minutes"). Several examples were noted during our videotape verification of Room Confinement Check Sheets.

- Failing to notify the Facility's social worker of all youth placed on suicide precautions (violates Policy #8.5 "Mental Health Care Program," "Suicide watch... shall be on a continuous basis until evaluation can be performed by a clinician"). We discovered two situations in March 2010 where two youths were placed on suicide precautions and the social worker was not notified.

- Failing to stay on post on the 3rd shift or otherwise leaving a housing unit unsupervised (violates Policy #15.4 "Shift Assignments" "To ensure proper supervision... juvenile caseworker positions should be located in or immediately adjacent to juvenile living areas"). Several youth and staff reported to us that direct care staff members on the 3rd shift congregate in the common area during the youths' sleeping hours, leaving the housing units unattended. Further, an incident report from March 11, 2010 revealed that a staff member assigned to monitor a housing unit left the dorm, and one of the youth attempted suicide by strangulation. Staff members were alerted to the situation by one of the other youth housed on the unit.

- During interviews, several staff indicated a blatant disregard for policy. One second shift employee believed it was unnecessary to conduct routine room checks of youth during the night. Another staff admitted to sleeping during the night shift. One second shift supervisor indicated that when staff appear to be sleeping, the supervisor is merely "telling them to walk around in order to wake them up" without instituting any disciplinary action.

Each of these situations represents staff misconduct and failure to follow policy and procedure that could result in serious harm to youth (by youth, by staff, or self-inflicted). While the Director had taken action against staff members who violated the Use of Force policy and other types of misconduct, the other issues appeared not to have been addressed in any substantive manner. Each of the issues — 15-minute confinement checks, suicide precautions, and youth supervision — should be part of routine oversight by the Facility's supervisors. This does not appear to be occurring with either the regularity or the keen eye required to ascertain whether staff are following policy consistently.

2. Use of Force and Isolation

The duty to protect youth from harm includes efforts to prevent youth from harming each other (i.e., fighting) and also efforts to ensure that, when staff must intervene physically, they do so using means that do not unnecessarily subject youth to pain or injury. Youngberg, 457 U.S. at 324. Attaining either of these objectives requires a facility to have detailed policies and procedures guiding the use of force that are in line with contemporary standards.

In many cases, youth-on-youth violence and other out-of-control behavior can be prevented with proper behavior management techniques and sound verbal de-escalation skills. Failing this, staff has a duty to reduce the harm that can occur by intervening with tempered, well-timed, well-executed physical restraint. Conditions of confinement at the Facility are unconstitutional because youth are being harmed or are at risk of harm, Terrebonne's policies and procedures substantially depart from generally accepted standards of care, and actual practices suggest that staff do not regularly follow these inadequate policies. Youngberg, 457 U.S. at 324.

a. Policy and Training

The Facility's Policy #15.3 "Use of Force" emphasizes using non-physical means to control the situation and, failing that, using only the minimum amount of force necessary to gain control. While this is a solid beginning, the policy lacks several key elements.

Terrebonne's policy does not provide specific training requirements for the use of force, stating only that "staff will be trained in approved methods." Currently there are no approved methods, indicating that the policy itself is largely aspirational. All staff reported that they had never been trained on specific restraint techniques and were forced to rely on their own judgment or training received in other settings (e.g., military or adult correctional facilities). Not only does this make enforcing Terrebonne's policy difficult, as there are no sanctioned techniques and therefore no techniques that are specifically prohibited, it also leaves staff with very few tools for safely and effectively responding to youth's aggression or out-of-control behavior. As a result, youth have been injured and the risk to both youth and staff safety is significant.

Further, knowledge about the safe use of chemical agents (oleo capsicum or "OC") was minimal among staff. Some staff were able to recount only basic facts about the use of OC (e.g., to deploy the spray in very short bursts; how to hold the canister), while others could not recall any specific information from the OC training they received. In addition, none of the staff interviewed were well-versed in proper OC decontamination procedures.

b. Improper and Unnecessary Use of Physical Restraint

Conditions of confinement at Terrebonne are unconstitutional because staff members use force that is either unnecessary or poorly executed. Generally accepted professional standards in a juvenile detention facility require that only appropriate levels of force are used, and only when a youth's behavior poses an imminent risk of harm to himself or others, or only when necessary to restore essential institutional security. See Youngberg, 457 U.S. at 324; Hudson v. McMillian, 503 U.S. at 6-9 (1992); Gomez v. Chandler, 163 F.3d 921 (5th Cir. 1999). Examples of the inappropriate or unnecessary use of force at Terrebonne include the following:

- On March 5, 2010, a youth went into the bathroom on the housing unit without permission. The youth complied with the staff's directive to come out of the bathroom, but balked at the staff's insistence that he be placed in isolation for this minor rule violation. When staff responded to the call for assistance to transport the youth to the isolation unit, the youth then became aggressive, resulting in a physical restraint, a botched mechanical restraint (staff could not remove the handcuffs), the use of OC spray, and two staff injuries. Given that the youth complied with the initial directive to leave the bathroom and (at that point) posed no threat to other youth or staff, the entire restraint and ensuing injuries could have been avoided.

- On March 4, 2010, a youth reportedly cursed at staff and then went to his bunk. Staff reported that he "took him out of bed" to transport him to the isolation unit for this minor rule violation. Video footage of this incident showed a single male staff person lifting a youth (who was simply lying on his bed, not threatening staff or other youth) off his bed and struggling with him as he carried him off the housing unit. Neither the written incident report nor the video footage suggested any reason why this youth's behavior could not have been handled on the unit, without physical intervention. The restraint was both unnecessary and very poorly executed. The staff member involved received a verbal warning for his involvement in this incident.

- On March 7, 2010, a youth approached another youth in the housing unit and began to punch him in the head and body. Two staff members pulled the two youth apart from behind. One staff member pulled one of the youth to another area of the unit, but did not secure him in any way (e.g., using an escort technique or other method to control the youth's movement until he was calm). That youth broke away, ran across the dorm and jumped over a table, and began to assault the other youth again. The staff members' physical intervention was so poorly executed that it provided an opportunity for another assault to occur.

c. Unnecessary Use of Chemical Agents and Restraint Chair

In determining whether a physical intervention may be unconstitutional, it is "proper to evaluate the need for application of force, the relationship between that need and the amount of force used, the threat 'reasonably perceived by the responsible officials,' and 'any efforts made to temper the severity of a forceful response.'" Hudson v. McMillian, 503 U.S. 1, 6-9 (1992). Conditions of confinement at Terrebonne violate youths' constitutional rights because the use of severe interventions at the Facility, such as chemical agents and restraint devices, are often not needed, when no threatening behavior is apparent, and before reasonable efforts to temper the precipitating behavior have been attempted.

Terrebonne policy permits the use of both OC spray and the restraint chair only in extraordinary circumstances. After these items are deployed, generally accepted professional standards dictate that nursing staff must assess the youth to determine whether any injuries or complications arise as a result of their use. Nonetheless, we identified a number of examples where staff used these types of force on youth who were not particularly threatening, and sometimes even compliant, or where nursing staff were not consulted after their use, both

violations of youths' constitutional rights. Hudson v. McMillian, 503 U.S. 1; Youngberg, 457 U.S. at 324. Examples include:

- On March 14, 2010, a female youth was booked into the Facility. The youth indicated that she did not want to take a shower but was very calm during this refusal, walking slowly with her arms wrapped around her torso. Staff tried to persuade her for a couple minutes, and then wheeled the restraint chair over to her. The youth became very distressed as the staff forced her into the chair; crying and thrashing her head about as the staff strapped her in. She remained in the restraint chair for 20 minutes. Although the Director of the Facility initially stated that this was a "good example of the use of the restraint chair," when questioned during the viewing of the videotape, he agreed that the youth did not pose a threat to herself or anyone else at the time. The videotape clearly shows that the restraint chair caused distress and was completely unnecessary in the circumstance in which it was used.

- On September 1, 2009, a male youth is seen on videotape hitting his head on a table one time. Staff walked over to him and engaged the youth in a short discussion. The youth got up from the table and walked to the unit door, on his own and without any threatening gestures or body language. As the restraint chair was brought toward him (it is unclear in the documentation why staff felt the restraint chair was necessary), the youth's behavior escalated and he began to resist staff's efforts to put him in the chair. The chair itself was off camera, and the restraint chair documentation indicates only that the youth was still in the chair at the first 15-minute check. The exact time of release is not noted. This is another example of a fully compliant youth who was placed in a mechanical restraint device that caused the youth significant distress. If used at all, the restraint chair should be reserved only for out-of-control youth who pose an immediate danger to themselves or others.

- On January 9, 2010, an incident report describes a youth refusing to comply with a directive to proceed to the isolation unit. The youth was seated at a table at the time. Staff did not attempt physical restraint nor did staff call for assistance. Given the youth's history of threatening staff verbally, the staff "thought the safest way for everyone would be to pepper spray the youth." The first burst of spray hit the youth on the side of the face and the youth "retreated," only to be hit with a second burst of spray on the neck. After being sprayed twice, the youth then became assaultive toward staff. Not only was OC spray used as a "first" rather than a "last resort," but it was used on a youth who was merely non-compliant and not physically threatening or aggressive toward staff. This youth did not receive medical attention following the use of OC spray as "no medical personnel were present." Staff was given a written warning and additional training for this incident, although the failure to provide prompt medical attention was not addressed.

- On February 2, 2010, a youth who assaulted another youth and became physically assaultive toward staff was sprayed with OC spray. The Chemical Agent Form indicates "No medical attention was needed." Failure to provide medical attention after such exposure to OC is a blatant departure from generally accepted professional standards.

These examples illustrate that Terrebonne's policy and practices around these issues are inadequate in terms of their ability to assure that staff use these tools only when necessary, or that youth receive medical attention following their use. Rather than protecting youth from harm, staff may in fact cause harm with their uncontrolled, poor execution and lack of medical attention following the incident.

d. Use of Excessive or Unnecessary Isolation

Terrebonne violates youths' constitutional rights by subjecting them to harmful and unnecessary restraint in isolation rooms. In addition, the amount of youth isolation at Terrebonne is excessive and disproportionate to the underlying disciplinary offense committed by the youth. Isolation in juvenile facilities should only be used when the youth poses an imminent danger to staff or other youth, or when less severe interventions have failed.[10] Morgan v. Sproat, 432 F. Supp. at 1132. Youth at Terrebonne are denied many of these basic protections.

Youth at the Facility are isolated at rates significantly higher than nationally reported field averages. Specifically, the number of room confinements and the average number of hours spent in isolation are approximately twice the Performance-based Standards ("PbS")[11] national field average ("NFA"), and the maximum time youth spend in confinement is approximately four times the PbS NFA.[12]

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[10] Examples of less severe interventions may include, among other things, a loss of certain privileges, a reduction in behavior management levels, or a restriction from participating in an optional activity.

[11] Performance-based Standards for Youth Correction and Detention Facilities is a self-improvement and accountability system used in 31 states and the District of Columbia to better the quality of life for youths in custody. PbS gives agencies the tools to collect data, analyze the results to design improvements, implement change, and measure effectiveness with subsequent data collections from within the facility and against other participating facilities. See http://www.pbstandards.org.

[12] We note that, while the PbS national field average is neither a representative nor a random sample, it is the best available database for external comparisons related to the occurrence of critical behaviors.

Table 1. Estimated TPJDC Rates of Specifi c Incidents for October 2009 as Compared with PbS Field Averages from the October 2009 National Data Collection period

Incident Category	Total Number	Terrebonne Rate	PbS National Field Average
Suicidal Behavior	9	0.627	0.119
Battery and Fighting	6	0.418	0.350
Pepper Spray	3	0.209	0.105
Isolations	76	5.299	2.84
Avg. Isolation Hours – Max.	3240	42.63	11.44
Avg. Isolation Hours – Med.	1620	21.32	11.44

While isolation in certain circumstances may clearly be warranted, use of isolation at the Facility is sometimes unnecessary. The following examples reflect the common practice at Terrebonne:

- On February 27, 2010, a female youth received an incident report for writing notes to male residents and for becoming rude and argumentative when presented with the infraction. According to the Facility records, she received 35 hours of isolation or room confinement for behaviors that could have been handled with a time out or some type of program restriction.

- On February 27, 2010, another youth received 31 hours of isolation for refusal to stop talking during sleeping hours in the boys' dorm. Again, this is an example where isolation is used although no lesser interventions had been attempted and no security threat was present.

Use of isolation for mere rule enforcement is unnecessary and inappropriate. In addition, the duration of such sanctions is far in excess of acceptable practice for such minor violations, and violates youths' constitutional rights.

3. Staffing

Some of the above described problems appear to have resulted from inadequate staffing. For example, this serious deficiency in staffing places youth at risk of harm because of staff fatigue, reduced accountability, overreliance on seclusion, and inadequate youth supervision. Terrebonne claims to maintain a 1:8 staffing ratio during waking hours.[13] However, we found

[13] Generally accepted professional standards in a juvenile detention center require a direct supervision ratio of a minimum of 1:8 during waking hours, and a minimum of 1:16 during sleeping hours. More staff-rich ratios may be required depending on the unique features and characteristics of the facility and youth.

that, typically, the direct supervision ratios are much lower and fall far below generally accepted professional standards. This deficiency contributes to violations of youths' constitutional rights to reasonably safe conditions of confinement. Youngberg, 457 U.S. at 324**.**

Terrebonne uses an unusual staff schedule. Four discreet teams of staff exist, and each team works a designated 12-hour shift on designated days, a 4-3 rotation with some built-in overtime. In other words, there are two different teams that cover the first shift (6:00 a.m. – 6:00 p.m.) and two different teams that cover the second shift (6:00 p.m. – 6:00 a.m.). Within each team, there is a shift supervisor and an assistant shift supervisor in addition to a standard rotation of post assignments, even though there are no official post designations. Staff rotate through various unofficial posts at three-hour intervals, which results in only one staff member assigned to the direct and continuous supervision of a living unit for a three-hour period of time while the additional staff perform other support duties in the "general vicinity." These "general vicinity" staff do not provide direct and continuous supervision but are available on short notice to supply back-up and support to the single staff member assigned to direct and continuous supervision. These "general vicinity" staff are counted into the staffing ratio by the Facility. This process represents a miscalculation of the ratio and a misrepresentation of the level of supervision.

4. Child Abuse Reporting

Generally accepted professional standards and Louisiana State Law require any caretaker who knows or suspects that an incident of alleged child abuse[14] has occurred must immediately initiate or cause to be initiated a report to the local law enforcement or social services agency.[15] This is so, whether or not the responsible individual believes the allegations to be credible. In other words, self-screening of abuse allegations undermines the important safeguard principles the standards are designed to maintain.

Because Terrebonne's Child Abuse Reporting policy provides the Director with latitude in determining the veracity of allegations prior to reporting to law enforcement and child welfare, youths' constitutional rights are violated. See Youngberg, 457 U.S. at 324. The policy states that the Director "shall promptly determine the facts surrounding the incident." In a small number of cases, this latitude has resulted in the Director's review and investigation of incidents of mistreatment alleged via the grievance system, when these allegations should also have been reported to law enforcement and child welfare. Failing to report allegations of abuse to an appropriate external agency is contrary to accepted professional standards (see PREA IN-2) and

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[14] Under Louisiana law, "child abuse" includes, among other things, "[t]he infliction, attempted infliction, or, as a result of inadequate supervision, the allowance of the infliction or attempted infliction of physical or mental injury upon a child... which seriously endanger the physical, mental, or emotional health and safety of a child...". La. Child. Code Ann. art. 603(1) (2010).

[15] See La. Child. Code Ann. art. 610 (2010). In addition, proposed Prison Rape Elimination Commission Standards for the Prevention, Detection, Response, and Monitoring of Sexual Abuse in Juvenile Facilities ("PREA") require that "investigations of abuse are prompt, thorough, objective and conducted by individuals who have specialized training in abuse involving young victims." PREA IN-2 (emphasis added).

is also a violation of State law. Allegations that were not reported to law enforcement are summarized below:

- On December 28, 2009, a youth alleged that staff "slung him across the dorm... slammed him into the wall... dragged him by his handcuffs and threw him into the door." The Director conducted an administrative investigation concluding that the staff had not violated Facility policies.

- On March 8, 2010, a youth alleged that he witnessed one staff choking another youth and another staff dragging a third youth to the isolation unit. While the reporting youth withdrew his compliant, the Director continued to administratively investigate the incident, finding the allegations to be unsubstantiated.

- During our interviews, a youth told us about an incident that occurred the day before in which he was reportedly "choked" by staff during a restraint. The youth had visible scratches on his neck. When we brought this incident to the attention of the Director, he indicated that he was already aware of it and had sent the accused staff home pending the outcome of an administrative investigation.

The Facility Director should have reported each of these occurrences to the law enforcement and child welfare agencies so that they could make an independent determination about whether the facts in each case warranted an investigation. The three investigatory bodies serve different purposes: 1) law enforcement determines whether a criminal violation occurred; 2) child welfare determines whether abuse or neglect occurred according to child welfare standards; and 3) the Facility determines whether policies and procedures were violated. Each of these entities must be informed of all allegations of abuse to ensure that all three inquiries are pursued. The Facility Director should never screen out an allegation or otherwise determine that it should not be reported to law enforcement and child welfare, no matter the findings of the administrative investigation. This is because law enforcement and social services agencies have specialized training in investigations of this type, where many internal facility investigators do not. Failure to make the reports improperly removes the oversight of external agencies from their shared duty to protect youth from harm.

5. Training on Prevention of Sexual Misconduct

While training on certain subjects at Terrebonne is adequate, one serious omission is staff training regarding custodial sexual misconduct. In the year since the discovery of allegations of serious and pervasive sexual misconduct at the Facility, Terrebonne has failed to develop a curriculum and mandate that all staff receive training in the prevention of this insidious danger. Given the apparent history of problems at the Facility, this omission is a substantial departure from generally accepted professional standards and in violation of the law. Youngberg, 457 U.S. at 324.

B. The Facility fails to adequately protect youth from self harm.

In addition to failing to protect youth from harm by staff, Terrebonne fails to adequately protect youth from self harm, and therefore violates youths' constitutional rights. Youngberg,

457 U.S. 307; Silva, 32 F.3d 566. Generally, youth in juvenile justice systems are at increased risk of suicide, but available statistics for the Facility reveal that youth confined at Terrebonne may be even more prone to engage in self harming behavior. For example, in October 2009, the rate of suicidal behavior at the Facility was more than five times the National Field Average. See Table 1.

Shockingly, we found that room checks for youth being held in isolation were routinely missed, and that staff often falsified the documentation of required room checks. Because youth held in isolation are known to be at heightened risk of suicide, this practice subjects youth at the Facility to serious risk of harm in violation of youths' constitutional rights. Helling, 509 U.S. at 25; Silva, 32 F.3d at 566. See also, Lewis v. Parish of Terrebonne, 894 F.2d 142 (5th Cir. 1990) (stating "one need not find a 'goose case' to imbue a warden at a jail with a constitutional duty to protect a prisoner prone to suicide from self destruction."). Also, we identified significant deficiencies in each of the core components of an adequate suicide prevention program. Taken together, these deficiencies place youth at serious risk of future harm. In each of these areas, we find that Terrebonne substantially departs from generally accepted professional standards in juvenile detention, and thus violate the youths' constitutional right to reasonably safe conditions of confinement. See Youngberg, 457 U.S. at 324. Each of the core components and the Facility's deficiencies in each area are described below.

1. Supervision

We reviewed the incident reports and observation forms for 17 youth placed on suicide precautions between September 2009 and March 2010. The observation forms, called "Confinement Check Forms," nearly always indicate that staff checked the safety and welfare of youth at exact 15-minute intervals. Not only is this level of precision impossible to achieve, it is counter to the best interest of the youth. The generally accepted practice is for youth on close observation to be checked at random (unpredictable) intervals, not to exceed 15 minutes. Further, we attempted to verify the data presented on the observation forms using videotaped footage of the overnight shifts on the isolation unit. In February 2010, large proportions of safety and welfare checks were determined to have been fraudulently recorded (i.e., the staff indicated a check was conducted on the observation form, but the videotaped footage revealed they did not actually do so). The following examples are illustrative of this extremely dangerous failure:

- A male detainee received a 48-hour confinement from February 21 through February 22, 2010. On the evening of February 21, the time under review ran from 2215 hours through 0530 hours or 7 hours and 15 minutes. This equates to 30 room checks. The log contains 30 entries by the staff, including the staff member's initials and the numerical behavior identifier, indicating that 30 room checks were made. However, the video shows only 11 room checks were actually performed.

- On the following evening the same detainee was confined from 2200 hours through 05:30 hours or 7.5 hours. This equates to 31 room checks. The log shows 26 entries by the staff members, including the staff member's initials and the numerical behavior identifier, thereby acknowledging that five room checks were missed. But the video shows only 19 room checks. Additionally, the 48-hour confinement extended over a

Monday and Tuesday, but there is no documentation that the detainee received any schooling or recreation.

- A detainee received a 32-hour room confinement beginning on February 27, 2010. For the evening of February 27, the time under review was from 2200 hours to 0530 hours or 7.5 hours. This equates to 31 room checks. Thirty-one room checks were entered on the form, including the staff member's initials and the numerical behavior identifier; but the video shows that only eight were made.

- On the following evening the same detainee was under review from 2200 hours through 0545 hours or 7 hours and 45 minutes. This equates to 32 room checks. Thirty-two room checks appear on the log, including the staff member's initials and the numerical behavior identifier; but the video shows again that only eight room checks were made.

- A female detainee received a 35-hour room confinement beginning on February 27, 2010. On the evening of February 27, the time under review ran from 2200 hours through 0600 hours this equates to 33 room checks. Thirty-three room checks are indicated on the log, including the staff member's initials and the numerical behavior identifier; but the video shows that only four room checks were made.

This pattern of overnight supervision creates a severe risk of harm to youth in the facility. The dangerousness of this situation cannot be overemphasized. Anytime a youth is locked in a room alone, the risk of self-harm increases. The combination of a youth assessed at higher risk of self-harm, isolation, and staff negligence in performing safety checks is a serious risk to youth safety.[16]

Additionally, Terrebonne has a single level of suicide precautions — "close observation" where youth are to be monitored at 15 minute intervals. Youth who are actively suicidal, either threatening or engaging in suicidal behavior, are routinely transported to the local emergency room for an evaluation and possible admission to a psychiatric hospital. Both documentation and reports from staff indicated that these high-risk youth are indeed transferred to the hospital for evaluation. However, generally accepted professional standards require that, pending transfer, these youth should be placed under constant observation by a dedicated staff member with no other responsibilities at the time (i.e., one-on-one supervision). This does not occur at Terrebonne, in violation of youths' constitutional rights to reasonably safe conditions. Youngberg, 457 U.S. at 324. Instead, youth awaiting transfer are only monitored at the 15-minute intervals prescribed for youth at much lower-risk of self-harm. This is an extremely dangerous practice given the youth's demonstrated active suicidal behavior.

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[16] As indicated previously, Parish Counsel forwarded us a list of measures the Facility has purportedly taken to ensure that, among other things, room checks are being performed as required by policy. A number of these reported measures should assist the Facility in monitoring staff in performing these duties, including plans to purchase an electronic tour guard system, and the periodic verification of overnight room checks with Facility digital video reviews. While these proactive measures are commendable, we are not in a position to confirm the adequacy of implementation of this corrective action.

2. Training

Adequate suicide prevention training standards require initial training for new staff that includes the instruction in environmental risk factors for suicide, individually predisposing factors, high-risk periods for incarcerated youth, warning signs and symptoms, the facility's suicide prevention procedures, liability issues, and a discussion of recent suicide attempts at the facility. In addition, the program should include a two-hour annual refresher training with a review of risk factors, warning signs and symptoms, and policy changes. All staff should also be trained in the use of emergency equipment (e.g., the rescue tool).

In late 2009, the Facility developed a training curriculum for suicide prevention. The curriculum content appears adequate. However, rather than the prescribed eight-hour training, the training session was only five hours of actual instruction time. Of the 52 direct care staff at the Facility, documentation indicated that 83% participated in the training. Several staff reported that training in this area was not considered to be mandatory and that staff who did not attend were not held accountable. Make-up sessions for those staff who did not attend had not been scheduled, nor had provisions been made for teachers and other non-direct care staff to attend the training. While most of the staff believed the Facility owned a rescue tool, none of the staff knew where it was or had been trained in how to use it. These inadequacies in the training for direct care and other Facility staff (e.g., teachers) is particularly concerning because most of a youth's self-harm behavior will happen in their presence, rather than in the presence of mental health staff who may have greater expertise in this area.

3. Intake Screening

Terrebonne's intake screening questionnaire asks only if the youth currently feels like hurting himself or herself. This single question is inadequate to the task of identifying youth at elevated risk of self-harm and is not aligned with contemporary standards. The screening should also include questions about past suicidal behavior, prior mental health treatment, recent significant losses, family/friend's history of suicide, and whether the youth demonstrated any risk of suicide during his or her previous stays at the Facility. Further, at Terrebonne, intake staff sometimes waits for the Facility's social worker to become available so that she can perform the screening, which is contrary to the standard endorsing immediate screening upon admission. Finally, the intake screening should be conducted by an individual who is trained to ask these questions competently. We learned that the Facility had just recently begun training intake staff on appropriate youth screening.

4. Communication

The strength of a facility's suicide prevention program rests on the quality of communication between direct care staff and mental health staff (who must be engaged in treatment to mitigate the youth's risk of self-harm). Communication between the direct care staff and mental health staff at Terrebonne is fragmented, at best. While a list of youth on suicide precautions is created each day, it is not broadly distributed and some of the direct care staff interviewed indicated that they were often unaware of which youth were on precautions. Further, we learned that twice during March 2010, youth were placed on suicide precautions by direct care staff and the social worker was not notified. We were informed that the direct care

staffs' experience with the previous social worker, who was unresponsive to most staff requests, led them to rely on the direct care supervisors for most decisions regarding mental health. Reportedly, this has been a difficult cycle to interrupt. Finally, there is no mechanism for the mental health staff to communicate with direct care staff regarding the source of potentially suicidal youth's stress, the specific risks posed, or coping mechanisms or activities that may help to mitigate the youth's risk of harm. Given that youth spend most of their time with direct care staff at the Facility, effective communication is vital if there is to be a coherent strategy for supporting youth during a time of crisis. Overall, the mechanisms for communication between direct care and mental health care staff at the Facility do not conform to contemporary standards of care.

5. Assessment

A youth's risk of self-harm is not static — it will increase and decrease depending on a range of influences (e.g., contact with family, outcomes in court, environmental stressors, treatment by mental health care staff, interaction with peers and direct care staff, etc.). Accordingly, the youth's need for precautions needs to be assessed frequently so that the level of supervision can be adjusted as necessary. Rather than using a structured assessment process on a daily basis, the social worker did not have a set schedule for follow-up with youth on suicide precautions. This was confirmed in our review of the mental health care files of five youth who had been on suicide precautions in early 2010. While detailed progress notes were kept on all contacts with youth, these contacts were not at the frequency (i.e., daily) prescribed by contemporary standards.

In large part, the lack of a clear and consistent procedure for on-going assessment of suicide risk can be attributed to the fragmentation of the mental health service delivery system at the Facility. The Facility's lead social worker, another part-time social worker, a counselor, and a variety of community-based counselors all provide mental health care services to Terrebonne youth. While the number of available counselors is encouraging, the fact that they do not communicate regularly, share information on clients, or have access to each other's progress notes means that the service delivery system is disjointed and a strong potential exists for a youth's mental health needs to fall through the cracks.

6. Housing

In early January 2010, the Facility began to maintain youth on suicide precautions in the general population, reassigning their bunks to ensure the best camera angle possible. But, youth on suicide precautions at the Facility are sometimes placed in isolation on the Delta dorm, in the individual cells on the housing units, or in the cells adjacent to the medical unit. While these assignments may be convenient for the staff who are responsible for supervising the youth, isolating youth at risk of self-harm can increase their sense of alienation and detachment from programming, and thus may actually increase their risk of self-harm rather than reduce it. When legitimate security concerns permit, facilities should house youth on suicide precautions in the general population, where their access to programming is more certain and they are able to maximize their interactions with staff and peers, which is likely to reduce the risk of self-harm. Several staff explained that the decision to house youth at risk of self-harm in the isolation unit was because of the availability of video surveillance. While video surveillance can be a good

supplement to staff supervision (but should never replace it), the extent to which staff actually monitor the video feed is questionable whether the youth is in the dorm or an isolation cell. Several of the isolation rooms are literally covered in graffiti made with writing implements or etched into the paint with sharp objects. In addition to the obvious concern about youth's access to sharp objects, the time required to complete the graffiti suggests that staff may not be monitoring the youth's behavior in the isolation rooms with any regularity.

More regularly housing youth on suicide precautions in the general population will be difficult to execute properly given the Facility's current staffing pattern. A single staff person is often responsible for supervising up to 20 youth on a housing unit. Without an improved ratio of staff to youth, maintaining youth at risk of self-harm on the housing units is impractical, if not dangerous.

7. Lethality Reviews

Following a serious suicide attempt[17] or a completed suicide, generally accepted professional standards require facilities to convene a multidisciplinary team to review the circumstances surrounding the incident to identify the conditions that gave rise to it. The discussion should include a review of the circumstances, facility procedures relevant to the incident, training issues, mental health services received by the youth, and recommendations for changes to Facility policy and procedure that could reduce the likelihood of a similar incident in the future. It is particularly concerning that, at Terrebonne, no such review process exists.

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Overall, Terrebonne's suicide prevention practices are far outside of contemporary standards for adequately protecting youth from self-harm. The fragmentation between and among direct care and mental health care staff, the failure to maintain close supervision of youth with demonstrated risks of self harm, the failure to conduct required room checks for youth at heightened risk of self harm (i.e., isolated youth), and the lack of any process to review the circumstances surrounding incidents of self-harm, despite their recent uptick, creates a very dangerous situation for the Facility, its staff, and the youth in its care, in violation of youths' constitutional rights. Youngberg, 457 U.S. at 307; Silva, 32 F.3d at 566.

C. The Facility fails to provide an appropriate housing classification system.

There are significant occurrences of youth violence at Terrebonne. For example, the most recent comparative statistics indicate that youth-on-youth assaults are approximately 20% higher than the National Field Average. See Table 1. Terrebonne lacks certain fundamental safeguards to adequately protect youth from harm by other youth. This violates youths' constitution rights to reasonably safe conditions of confinement. Youngberg, 457 U.S. 307. See also, Farmer v. Brennan, 511 U.S. at 825. Specifically, one key strategy for protecting youth from harm is to identify those at highest risk of causing harm to other youth and supervising

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[17] We identified two incidents in February 2010 where youth engaged in serious suicide attempts and/or were considered to be at such heightened risk of suicide that protective hospitalization was required.

them intensively to mitigate this risk. Accurately identifying high-risk youth requires an objective process that is consistently implemented at admission. Once identified, high-risk youth must be supervised more closely and supported with other behavior management techniques to either limit their access to potential victims or to help them to develop the skills they need to control their aggression. Adequate standards of care require a structured classification process to guide housing and programming decisions. Terrebonne's lack of an adequate housing classification system substantially departs from generally accepted professional standards in juvenile detention, and thus violates the youths' constitutional right to reasonably safe conditions of confinement. Youngberg, 457 U.S. 307

Terrebonne's policy requires each youth to be "classified according to age, sex, delinquent orientation, level of risk and program needs" and that youth with special needs must receive "special consideration." However, the policy provides no procedures, tools or instruments toward this end. Once the youth is classified, the policy offers no guidance as to what a classification to a certain category would mean in terms of the youths' housing or supervision. Again, this policy appears to be aspirational but has no bearing on the actual practices at the Facility. The Facility Director and various supervisors indicated that they currently make efforts to place more aggressive male youth in a housing unit separate from less aggressive males, but these determinations were entirely subjective and based on either recollections from a youths' previous admissions or his behavior during the current incarceration. Bed assignments are made at the discretion of unit supervisors. Aside from grouping more aggressive youth together, no additional staffing or programming enhancements were in place to address the heightened risk.

While both the policy and the current effort to segregate more violent youth from less violent youth indicate the Facility is aware of the need for strategic housing decisions, the procedures for classifying youth are well outside contemporary standards of care. As noted above, the Facility's policy implies a structured classification process, but it is entirely subjective, unsupported by procedures and tools to assess youths' risk, silent on the process for making subsequent unit and bed assignments, and lacks enhancements to supervision and programming to mitigate the risks posed by highly aggressive youth. As a result, the classification process at the Facility is ineffective to the task of protecting youth from harm.

D. The Facility fails to adequately report incidents and collect key data.

The purpose of a facility incident reporting process is to have a full and complete record of what occurs in the facility so that administrators can identify the various conditions that create the opportunity for incidents to occur, can monitor staff responses, can identify training needs, and can develop prevention strategies that could make each type of incident less likely to occur in the future. The overall process for incident reporting at Terrebonne is far below generally accepted practices creating risks of undetected or unidentified harm, in violation of youths' constitutional rights. See Youngberg, 457 U.S. at 307; Helling, 509 U.S. at 25. An adequate incident reporting and data collection system should be implemented at Terrebonne to ensure that remedial measures are appropriately implemented and sustainable.

Terrebonne does not have a stand-alone incident reporting policy; rather, procedures for reporting incidents are embedded within a much broader policy. While the section of the policy

pertaining to incident reporting includes a comprehensive list of the types of incidents that must be reported, it provides no guidance on the required content of the reports or any procedures for administrative review.

If incident reports are to be useful in the effort of preventing institutional misconduct and protecting youth from harm, they must also provide a complete account of the event. Only when these details are known can the underlying causes of youths' misbehavior be addressed. Further, improving the quality of staff responses to misconduct requires an understanding of the precise way in which staff handled the incident. We reviewed approximately 150 incident reports generated at the Facility in early 2010. Key omissions across these reports include: 1) the number of youth and staff present at the time of the incident, and the location of individuals present; 2) activity that occurred just prior to the incident; 3) a thorough description of the incident; 4) specificity as to how staff responded and intervened; and 5) witness statements from all staff and youth present.

Perhaps as a result of these inadequacies in the content of the incident reports, aggregate data on the types of incidents occurring at the Facility are difficult to reconcile with the incident reports themselves. Incidents may be variously marked as "horseplay," "pushing," "battery," or "fighting" but the distinctions in the written narratives are unclear. Terrebonne's leadership discussed the difficulty experienced in responding to our document request because many of the incident reports were either mislabeled or did not clearly specify the type of incident that occurred.

E. The Facility fails to provide adequate quality assurance systems.

Terrebonne does not currently have any structured process for quality assurance. In fact, Facility leadership indicated that the assimilation of documents in preparation for our visit marked the first time that Facility staff had begun to look at the patterns that exist across the various documents needed to illustrate the Facility's practices. While individual incidents and situations are reviewed by the Facility's management team on a daily basis, the historical lack of oversight of the program, its various components and how they intersect and, at times, interfere with each other have contributed to an environment that does not adequately protect youth from harm from other youth, staff, or themselves. An adequate quality assurance program should be implemented at Terrebonne to ensure that remedial measures are appropriately implemented and sustainable.

* * *

The Parish should expeditiously implement the following remedial measures to correct the constitutional deprivations outlined above. The remedial measures below are consistent with generally accepted juvenile corrections standards.

IV. REMEDIAL MEASURES

A. Protection from Harm by Staff

1. Adopt a zero-tolerance policy for abuse of youths by staff and other youths, including sexual abuse.

2. Review all incident reports at least three times per week to determine whether staff may be violating policies, procedures, and rules, and document the review.

3. Review all youth grievances at least three times per week to determine whether staff may be violating policies, procedures, and rules, and document the review.

4. Conduct routine and unpredictable audits of video recordings and surprise in-person visits to the Facility during the overnight shift and on weekends to determine whether staff may be violating policies, procedures and rules.

5. Promptly investigate any incident where staff are suspected of possible violations of policies, procedures, or rules.

6. Impose and document appropriate counseling, reprimands, training, or sanctions on staff found to have violated policies, procedures, or rules.

7. Develop and implement an age-appropriate use of force curriculum (including, among other things, de-escalation techniques and an appropriate continuum of interventions short of physical force).

8. Provide a minimum of eight hours of competency-based training for all staff on the approved use of force curriculum (including use of physical force, physical restraints, mechanical restraints, any fixed-restraints, and any chemical agents), provide new employee training, and provide two hours of annual refresher training.

9. Prohibit the use of fixed-restraints and chemical agents, except in extraordinary circumstances (e.g., when less severe interventions are unsuccessful or unavailable).

10. Adopt an adequate continuum of disciplinary sanctions, restricting the use of isolation to situations where a youth poses an imminent threat to themselves or others, or when less severe disciplinary measures have proven ineffective.

11. Prohibit the use of disciplinary isolation longer than 72 hours, except in extraordinary circumstances and with the express authorization of the Facility Director. Thorough documented justification shall be maintained for any use of isolation longer than 72 hours.

12. Ensure that direct care staffing ratios are maintained at a minimum of 1:8 during waking hours and 1:16 during sleeping hours, and that staff are in the same room as the youth, awake, and alert.

13. Ensure that all youth allegations or staff reports of child abuse are referred to the appropriate external agency immediately, and no later than the end of the employee's shift.

14. Provide a minimum of two hours of competency-based training for all staff on the identification and prevention of custodial sexual misconduct or other sexual misconduct, and provide new employee and annual refresher training.

B. Protection for Self-Harm

1. Provide a minimum of eight hours of competency-based suicide prevention training for all staff which includes: the environmental risk factors; individually predisposing factors; high-risk periods; warning signs and symptoms, the Facility's suicide prevention procedures; liability issues; a discussion of recent suicide attempts at the Facility; the use of a rescue tool. This should be part of new employee training, and there shall be four hours of annual refresher training. Staff shall be certified in CPR and first aid.

2. Revise the intake screening questionnaire to include, among other things, whether the youth feels like hurting himself or herself, any past suicidal behavior (in a facility or otherwise), any prior mental health care treatment, any recent significant losses, family or friends' history of suicide.

3. Require direct care staff to immediately notify mental health care staff any time a youth is placed on suicide precautions.

4. Notify all direct care staff on a daily basis of all youth on suicide watch precautions.

5. Provide a mechanism where mental health care staff provide critical information about youth on suicide precautions to direct care staff regarding known sources of stress to potentially suicidal youth, the specific risks posed, or coping mechanisms or activities that may help to mitigate the risk of harm.

6. Ensure that youth on suicide precautions are re-assessed at least three times per week by the mental health care staff to determine whether the level of supervision should be raised or lowered.

7. Ensure that all mental health care staff within the Facility have access to critical information for youth on suicide precaution (e.g., progress notes from all treating clinicians).

8. Prohibit the routine use of isolation rooms for youth on suicide precautions. Ensure that isolation rooms are only used when legitimate security concerns exist and are documented.

9. Ensure that youth who have been identified with a high risk of suicide (e.g., selected for transfer to a hospital) receive one-on-one supervision by a direct care staff with no other duties until the youth is transferred out of the Facility.

10. Ensure that the safety and welfare of all youth in isolation is verified by staff at unpredictable intervals not to exceed 15 minutes, and that each check is accurately documented.

11. Ensure that all serious suicide attempts are reviewed by a multidisciplinary team to review all relevant facts and circumstances surrounding the incident, and implement any appropriate remedial action.

C. Housing Classification

1. Adopt and implement an adequate objective housing classification instrument and system that determines a youths' risk of engaging in serious institutional misconduct (e.g., assaultive behavior). The scored factors should include, among other things, a youth's prior institutional misconduct. Administrative overrides of risk classification should not exceed 20%.

2. Ensure that youth are classified to an appropriate housing unit and bed within 24 hours of intake, and that high-risk youth are housed separately from low-risk youth.

3. Ensure that youth who commit serious institutional misconduct after their initial classification are reassessed within 72 hours.

D. Incident Reporting and Data Collection

Ensure that incident reports contain all material information including, at a minimum, a) the number of youth and staff present at the time of the incident, and the location of individuals present; b) activity that occurred just prior to the incident; c) a thorough description of the incident; d) specificity as to how staff

responded and intervened; and e) witness statements from all staff and youth present.

E. Quality Assurance

Develop and implement an effective quality assurance program to ensure that policies, procedures, and practices at the Facility are being followed, and whether policies require improvement or updating. The program should: a) create standards that reflect current facility policies; b) establish a process for auditing facility practices that includes document review, interviews with youth and staff, and observation of operational procedures and programs; c) draft a written report on the level of compliance with each quality assurance standard; and d) create corrective action plans to address the deficits noted by the quality assurance audits.

* * *

Please note that this letter is a public document. It will be posted on the Civil Rights Division's website. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post the letter on the Civil Rights Division's website until five calendar days from the date of this letter.

Thank you for your cooperation and assistance with this investigation. We hope that these recommendations will be received in the spirit of assisting in our mutual goal of ensuring the safety and security of youth in the Terrebonne Parish Juvenile Detention Center. We look forward to working with you to negotiate a resolution of the deficiencies described in this letter.

If you have any questions regarding this letter, please call Jonathan M. Smith, Chief of the Civil Rights Division's Special Litigation Section at (202) 514-6255.

Sincerely,

s/ Thomas E. Perez

Thomas E. Perez
Assistant Attorney General

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Terrebonne Parish Juvenile Detention Center

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