



U.S. Department of Justice

Civil Rights Division

*Special Litigation Section - PHB
950 Pennsylvania Ave, NW
Washington DC 20530*

MAR 20 2012

The Honorable Phil Bryant
Governor
State of Mississippi
550 High Street
Jackson, MS 39201

Re: Investigation of the Walnut Grove Youth Correctional Facility

Dear Governor Bryant:

The U.S. Department of Justice's Civil Rights Division has completed its investigation into the conditions of confinement at the Walnut Grove Youth Correctional Facility ("WGYCF" or "Facility") in Walnut Grove, Mississippi. Our investigation was conducted pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 ("CRIPA"), and the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141 ("Section 14141"). Both CRIPA and Section 14141 give the United States Department of Justice authority to seek a remedy for a pattern or practice of conduct that violates the constitutional rights of youth. We conclude that the State of Mississippi is deliberately indifferent to the constitutional rights of young men confined at WGYCF. Evidence discovered at WGYCF reveals systematic, egregious, and dangerous practices exacerbated by a lack of accountability and controls.

We conclude that youth at WGYCF are not receiving constitutionally adequate care. Specifically, we find that:

- WGYCF is deliberately indifferent to staff sexual misconduct and inappropriate behavior with youth. Further, staff fails to report allegations of staff sexual abuse to supervisors and State officials, as required by law.
- WGYCF is engaged in a pattern or practice of using excessive force against youth. Staff often use excessive force as a first response, not as a last resort, including the use of pepper spray in excessive amounts. Further, staff fails to adequately report and investigate uses of force.
- WGYCF is deliberately indifferent to gang affiliations within the ranks of correctional staff.

- WGYCF is deliberately indifferent to the serious risk of harm, through physical and sexual assault, to youth posed by fellow youth. Corrections officers fail to supervise and take reasonable steps to protect youth.
- WGYCF is deliberately indifferent to the suicide risks and serious mental health needs of its youth. The Facility lacks sufficient qualified mental health professionals to provide proper mental health care and current staff is not appropriately trained to address suicidal youth.
- WGYCF is deliberately indifferent to the serious medical needs of its youth.

The widespread and significant deficiencies at WGYCF violate the Eighth Amendment's mandate that imprisoned youth be protected from harm and provided adequate medical and mental health care. The attached Report discusses these findings in greater detail.

We announced our investigation into WGYCF on October 25, 2010. In January 2011, we conducted an on-site inspection of WGYCF accompanied by expert consultants in the areas of corrections, medical care, and mental health care. Before, during, and after our tour, we reviewed extensive documentation provided by the State, including policies and procedures, incident and use of force reports, use of force videos, unit logs, youth rule violation reports, youth grievances, youth injury lists, youth death reports, unit floor plans, staffing discipline reports, internal investigations, after action reports, facility maintenance reports, training materials, medical and mental health records, and related material. Additionally, we interviewed WGYCF administrators, staff, and between 300 – 400 youth. We thank the State for the assistance and cooperation extended and acknowledge the courtesy of the State officials and counsel involved in this matter.

After the start of our investigation, the State conducted an internal review of WGYCF to see if it was operating consistently with sound correctional practices. In March 2011, the State issued a report that identified deficiencies in WGYCF that are consistent with the findings in our Report. We are encouraged that the State recognizes the need for fundamental change, and hope that there is a desire to work toward an amicable resolution in this matter. We hope that our findings will be received in the spirit of assisting in our mutual goal of ensuring that youth at WGYCF receive constitutionally adequate care.

We are obligated to advise you that, in the unexpected event that we are unable to reach a resolution regarding our concerns, the Attorney General is authorized to initiate a lawsuit pursuant to CRIPA 49 days after your receipt of this letter to correct deficiencies of the kind we have identified. See 42 U.S.C. § 1997b(a)(1). We would very much prefer, however, to resolve this matter by

working cooperatively with you. Accordingly, the lawyers assigned to this matter will be contacting the attorney for the State to discuss next steps in further detail.

Please note that this letter and the accompanying Report are public documents and will be posted on the Civil Rights Division's website. If you have any questions regarding this matter, please call Jonathan M. Smith, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-6255.

Sincerely,



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**Investigation of the
Walnut Grove Youth Correctional Facility
Walnut Grove, Mississippi**



**United States Department of Justice
Civil Rights Division**

March 20, 2012

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SUMMARY OF FINDINGS

The United States Department of Justice (“DOJ”) conducted an investigation of Walnut Grove Youth Correctional Facility (“WGYCF” or “Facility”) in Walnut Grove, Mississippi, pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 (“CRIPA”), and the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141 (“Section 14141”). Both CRIPA and Section 14141 give DOJ the authority to seek a remedy for a pattern or practice of conduct that violates the constitutional rights of youth. Consistent with the statutory requirements of CRIPA, we now report the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to address the deficiencies we have identified. 42 U.S.C. § 1997b.

We conclude that the State of Mississippi violates the constitutional rights of the young men confined at WGYCF. Evidence discovered at WGYCF reveals systematic, egregious, and dangerous practices exacerbated by a lack of accountability and controls. Mississippi officials are aware of and disregard an excessive risk to youth health and safety.

Our findings are, in large measure, consistent with the State’s own conclusions about the unmet needs of youth in WGYCF, and the Facility’s deficiencies and weaknesses.¹ Youth are not receiving constitutionally adequate protection. We have made a point to include these State conclusions and admissions in this letter, and we adopt them as part of our findings. Specifically, we found that:

1. WGYCF is deliberately indifferent to staff sexual misconduct and inappropriate behavior with youth. The sexual misconduct we found was among the worst that we have seen in any facility anywhere in the nation. Further, staff fails to report allegations of staff sexual abuse to supervisors and State officials, as required by law.
2. WGYCF is engaged in a pattern or practice of using excessive force against youth. The State acknowledges, and we agree, that staff often uses excessive force as a first response, not as a last resort, including the use of pepper spray in excessive amounts. Further, staff fails to adequately report and investigate uses of force.
3. WGYCF is deliberately indifferent to gang affiliations within the ranks of correctional staff.
4. WGYCF is deliberately indifferent to the serious risk of harm to youth posed by fellow youth. The State acknowledges, and we agree, that corrections officers fail to supervise youth, particularly youth known to be violent, resulting in a high rate of ongoing harm and serious risk of harm. There is significant evidence that the Facility fails to take reasonable steps to protect youth from sexual and physical assault from other youth.
5. WGYCF is deliberately indifferent to the suicide risks and serious mental health needs of its youth. The State acknowledges, and we agree, that the Facility lacks sufficient

¹ See MGT America, Operation Assessment of the Walnut Grove Youth Correctional Facility (2011).

qualified mental health professionals to provide proper mental health care and current staff is not appropriately trained to address suicidal youth.

6. WGYCF is deliberately indifferent to the serious medical needs of its youth. The State acknowledges, and we agree, that staff provide inadequate medical care.

The widespread and significant deficiencies in the Facility violate the Eighth Amendment's mandate that imprisoned youth be protected from harm and provided adequate medical and mental health care.

I. INVESTIGATION

On October 25, 2010, we notified Mississippi officials of our investigation. On January 10-13, 2011, we conducted an on-site inspection of WGYCF accompanied by expert consultants in the areas of corrections, medical care, and mental health care. Before, during, and after our tour, we reviewed extensive documentation provided by the State, including policies and procedures, incident and use of force reports, unit logs, youth rule violation reports, youth grievances, youth death reports, unit floor plans, staffing discipline reports, internal investigations, after action reports, facility maintenance reports, youth injury lists, use of force videos, training materials, medical and mental health records, and related material. Additionally, we interviewed WGYCF administrators, staff, and 300-400 youth. We observed youth in a variety of settings, including their living units, common areas, library and classrooms. Consistent with our commitment to conduct a transparent investigation and provide technical assistance, our expert consultants conveyed their initial impressions and concerns to the State during exit conferences held at the conclusion of the tour.

After the start of our investigation, and heightened public interest in the program and operations of WGYCF,² the State conducted an internal review of the Facility to see if it was operating consistently with sound correctional practices. On January 27, 2011, the State commissioned a report with MGT America ("MGT") to conduct an independent review of the programs and operations of WGYCF.

In its March 2011 report, the State found deficiencies in WGYCF that are consistent with our findings, such as:

- high incidences of use of force, with specific reference to excessive use of chemical agents on youth for blocking food slots;
- inadequate staff training;
- low staffing levels;
- inadequate staff supervision;
- inadequate sick call process and medical assessments;

² In 2010, the Southern Poverty Law Center ("SPLC") sued the State in a class action lawsuit alleging unconstitutional conditions of confinement at WGYCF. C.B. v. Walnut Grove Correctional Authority, Case No. 2010-cv-663 (D.MS.). On February 3, 2012, SPLC and the State filed a joint motion for preliminary approval of two proposed Consent Decrees, one governing WGYCF and the other governing a new Youth Offender Unit to be located at the Central Mississippi Correctional Facility by no later than December 2012. The parties also filed two Memoranda of Agreement relating to the provision of mental health care services at these facilities.

- inadequate mental health care, including a deficient special needs unit and suicide prevention program;
- unnecessarily housing youth age 17 and younger in the facility when they would be better served with educational and rehabilitative services in the State's juvenile system; and,
- inadequate control of contraband.

During our site visit in January 2011, we conveyed our significant concerns with the Facility's practices that deviated from constitutional norms, and our expert consultants provided technical assistance in the areas of protection from harm, suicide prevention, mental health care and medical care during an extensive exit conference.

II. BACKGROUND

WGYCF is a 1,500-bed prison that houses young men aged 13-22 years who are in the custody of the Mississippi Department of Corrections ("MDOC"). The Facility, opened in March 2001, is authorized by Miss. Code Ann. § 47-5-943 (West 2007) specifically for the incarceration of male adolescents who are convicted as adults in criminal court.

The Facility has an authorized correctional officer complement of 245 staff (162 officers and 82 security supervisors). Between May 2001 and March 2010, the population of WGYCF has more than tripled, from 350 to approximately 1,200 adolescents.³ Twenty percent of the youth are White, 79% of the youth are Black, and 1% of the youth are categorized as other.

The Facility is owned by the Walnut Grove Development Authority ("WGDA"). The WGDA contracts with a private, for-profit company, the GEO Group, Inc. ("GEO"), to operate the Facility. GEO assumed operations of the Facility in August 2010, after acquiring and merging with Cornell Companies, Inc. ("Cornell"), which had operated the Facility since September 2003. Following GEO and Cornell's merger, key personnel, policies and training at WGYCF did not change substantially, despite GEO's claim that it made corrective reforms to reflect the GEO philosophy. The mental health and medical staffs at WGYCF are employed by Health Assurances as contract staff; they are not employees of GEO or the State.

All cells in WGYCF are configured for double-cell occupancy, but some special management units only house one youth per cell. The Facility has six main housing units and a special observation unit. A zone is two or more housing units, both of which are observed by the same control center. Each housing unit in a zone has a large day room and contains approximately 32 double cells for a zone capacity of 64 youth. The Facility also has a recreation yard, library, and educational and vocational sections. In addition, there is a medical unit, but no special unit designated for in-patient mental health care treatment. There is, however, a "special needs" unit where young men on medical observation or suicide watch are housed.

³ The persons incarcerated at WGYCF are called "inmates" by the State of Mississippi. We refer to them as "youth" throughout this Report.

III. FINDINGS

In violation of their constitutional rights, youth at WGYCF are not adequately protected from harm by staff or other youth, suffer sexual abuse, are denied adequate medical and mental health care, are not protected from suicide risk, and are inadequately supervised. These unsafe conditions of confinement create an environment that is dangerous and detrimental to youth development and well-being.

The constitutional deprivations uncovered by our investigation are not the result of isolated incidents or the misconduct of a few WGYCF staff members. Instead, WGYCF's deliberate indifference to protecting youth from harm is a systemic failure. We did our best to verify all of the allegations that we received during our investigation. In some cases, however, we relied on witness statements, due to the Facility's poor recordkeeping.

Indeed, many of the youth 17 and younger at WGYCF suffer disproportionately from the Facility's deficiencies and weaknesses. Their vulnerability to harm from older, stronger inmates expose this group to increased risks of harm. The State recommends, and we agree, that the 45-50 youth currently housed at WGYCF who are age 17 or under should be housed in the State's juvenile system, which would be better suited to provide the most effective care.⁴

A. THE STATE OF MISSISSIPPI IS FAILING TO ADEQUATELY PROTECT YOUTH AT WGYCF FROM HARM.

WGYCF does not provide humane conditions of confinement or take reasonable measures to guarantee the safety of youth as required by the Constitution. Farmer v. Brennan, 511 U.S. 825, 832 (1984). Young men imprisoned at WGYCF are protected by the Eighth Amendment's prohibition against cruel and usual punishment. See Estelle v. Gamble, 429 U.S. 97 (1976).

The Constitution imposes upon jurisdictions a duty to assume responsibility for a prisoner's safety and general well-being. County of Sacramento v. Lewis, 523 U.S. 833, 851 (1998). Generally, state and local governments must provide confined persons with reasonably safe conditions of confinement. See Bell v. Wolfish, 441 U.S. 520 (1979). The Eighth Amendment – as applied to the states through the Due Process Clause of the Fourteenth Amendment – also requires that prisoners “receive adequate food, clothing, shelter, and medical care.” Farmer, 511 U.S. at 832.

Incarcerated juveniles at WGYCF have a constitutional right to be protected from physical abuse and from assaults. Id. at 834 (it is unconstitutional to incarcerate an inmate under conditions posing a substantial risk of serious harm or when prison officials are deliberately indifferent to the inmate's safety); Longoria v. Texas, 473 F.3d 586, 592 (5th Cir. 2006) (prison officials have a constitutional duty to protect inmates from violence at the hands of their fellow inmates). The State shows deliberate indifference and fails to protect youth from harm in seven major areas: 1) sexual misconduct; 2) use of excessive physical force; 3) excessive use of

⁴ On February 3, 2012, SPLC and the State filed a joint motion for preliminary approval of a proposed Consent Decree governing a new Youth Offender Unit to be located at the Central Mississippi Correctional Facility by no later than December 2012.

chemical agents; 4) poor use of force polices, reporting, training and investigations; 5) youth-on-youth violence and sexual assault; 6) inadequate staffing; and 7) inadequate life systems.

1. The State's deliberate indifference to the high incidences of sexual misconduct between youth and staff is in violation of the Eighth Amendment.

During our investigation, we found that staff sexual misconduct with youth in their custody occurred on a monthly basis, at a minimum. 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 in the Facility. We reviewed incidents starting in July 2009 through May 2010 of sexual misconduct between youth and staff, including the Facility's disposition in each matter. We find that WGYCF is aware of the pervasiveness of staff sexual misconduct, but has failed to take any steps to prevent it beyond terminating staff caught in the act. This blatant disregard for the youth's safety and well-being is unconstitutional. Farmer, 511 U.S. at 825. Barney v. Pulsipher, 143 F.3d 1299, 1310 (10th Cir. 1998) (holding that forced oral sex and sexual assault of adult prisoners are "sufficiently serious to constitute a violation under the Eighth Amendment").

The Facility's pervasive level of brazen staff sexual misconduct is stark evidence of a dysfunctional system. Despite being aware of the regular sexual misconduct or inappropriate behavior between staff and youth, the Facility fails to provide specific training to address sexual misconduct between its staff and youth. WGYCF's lack of programmatic and operations response to staff sexual misconduct constitutes deliberate indifference. The failures to detect and eradicate inappropriate sexual conduct between staff and youth stem from inadequate staffing levels, poor staff deployment practices, the absence of staff training, lack of correctional-appropriate privacy structures in showers, and lack of staff accountability. The Facility has failed to institute policies, procedures, and training to both proactively and reactively address this unlawful conduct.

An egregious example of staff sexual misconduct occurred in April 2010, when a nurse was observed by a corrections officer having sexual intercourse with a youth in the medical department restroom. The nurse, while in the sexual act, yelled "close the door!" to the corrections officer who had interrupted her in the midst of sexual relations. The officer informed the nurse that he was immediately informing a Captain. Upon returning, the corrections officer observed the nurse and the youth still having sexual intercourse. In response, the nurse called out "close the fucking door!" Once finished, the nurse confronted the corrections officer asking "why couldn't [he] wait until they got done before coming back?" The corrections officer escorted the youth back to his cell and filed a report with a Captain. The nurse admitted to having sexual intercourse with the youth and was terminated and arrested.

WGYCF's failure to train staff, failure to provide adequate supervision, failure to provide adequate privacy for showering, and failure to provide follow-up care to sexually abused youth, creates an environment ripe for sexual misconduct and inappropriate relationships between youth and staff. Between July 2009 and May 2010, allegations of sexual misconduct and inappropriate behavior led to criminal charges against at least two and the termination of at least 13 staff members. While there should be no sexual contact between staff and prisoners, all physical abuse of youth under the age of 18 and sexual misconduct between an adult staff member and an

incarcerated youth under the age of 18 is a felony sexual battery must be reported to the Sheriff for criminal prosecution and to the State of Mississippi, pursuant to its child abuse laws.⁵

The imbalance of power that leads to adult-youth sexual exploitation is exacerbated in the prison setting, where youth are easily coerced out of fear of reprisal. For instance, a staffer can promise better treatment or threaten poor treatment if the incarcerated youth does not cooperate with the sexual act. Or, sex between staff and youth can be used as a bartering device, where staff gives favors (like access to better work assignments, food, telephone privileges, clothing or drugs) in exchange for sex with a youth.⁶ By law, sex between staff and incarcerated youth is never consensual.

a. Failure to Train Staff

WGYCF does not train staff on custodial sexual misconduct. Even though Facility records show staff sexual misconduct occurred on a monthly basis, WGYCF has not implemented policies, developed a curriculum or mandated that all staff receives training in the prevention of sexual misconduct and inappropriate behavior. Given the prevalence of sexual misconduct at this Facility, this failure to act bespeaks deliberate indifference and is a violation of the law. Farmer, 511 U.S. at 825. It is imperative that the State institute policies, conduct training and provide the proper staff supervision to eliminate staff sexual misconduct at the Facility.

We found numerous inappropriate relationships between staff and youth at WGYCF, including: officers providing their personal cell phone numbers to youth; wiring money to youth's commissary accounts or providing the officer's banking information; allowing youth to kiss them on their neck; and, providing incriminating letters and pictures of themselves to youth. Staff also provided contraband to youth, such as: cell phones, currency and sharpened objects. Between January and October 2010, 11 officers found to have engaged in inappropriate relationships with youth were terminated. Clearly, the State must also evaluate its hiring practices.

b. Failure to Supervise

Further, at the Facility, there are no systems in place to identify and prevent sexual misconduct or inappropriate relationships between staff and youth. The State found, and we agree, that the shift assignments for correctional officers do not currently ensure that a sufficient number of supervisors and correctional officers are assigned to each one of the four 12-hour shifts to cover the young men housed at the Facility.

The following examples illustrate disturbing evidence of systemic sexual misconduct between staff and youth, which results from inadequate supervision and control:

In May 2010, a correctional officer alleged that a nurse had inappropriate sexual contact with a youth. The corrections officer, while searching for an unaccounted for youth, claimed that

⁵ Miss. Code Ann §§ 43-21-105(d) (2010); 43-21-353 (2007); Miss. Code Ann. § 97-3-95(2) (1998).

⁶ Brenda Smith, Sexual Abuse Against Women in Prison, 16 CRIM. JUST. 30, 34 (2001).

she heard “moaning and groaning sounds coming from the [employee] bathroom” and an unidentified voice from the restroom asking “where do you want me to put it?” The officer left the area to get another officer. Upon returning, the officer observed the accused nurse and the unaccounted for youth exit the restroom together. The youth claimed that while waiting in an exam room, he used the employee restroom. A nurse entered, and initiated and performed oral sex on the youth. The nurse denied the act occurred; however, the Facility Investigator referred the case to the Sheriff’s Office for further investigation. With proper supervision, the youth should not have had access to the employee bathroom and the nurse should not have been left alone with the juvenile for an extended span of time.

In August 2009, a female correctional officer removed her shirt and threw it on the floor while in her security post in the housing unit control center, which is positioned on a higher level than the ground floor of the unit. The correctional officer was recorded on camera bending over and moving provocatively in front of the youth housed in her unit. A youth was able to climb onto the ledge just beneath the control center window and positioned himself in front of the control center window. This episode continued during a *four* hour time span. During this time, the correctional officer can be seen on video extending her hand from the control center window and touching the youth inappropriately.

The failure to supervise staff and youth at WGYCF is not only egregious on its face; it also has serious security and safety implications. Further, the physical design of WGYCF contributes to the officers’ inability to appropriately monitor youth. For instance, the showering facilities are particularly inadequate to protect youth from sexual victimization. The Facility showers are located on the corners of each unit at the end of the hall. The showers allow naked youth to be viewed from the lower level, upper level and other areas in the unit by all staff, male and female, including medical personnel, and mental health professionals. The Facility needs to redesign the shower to ensure both security and privacy and should restrict access to male corrections officers on the unit during showering.

2. WGYCF is engaged in a pattern or practice of using excessive physical force against youth.

In its March 2011 report, the State acknowledged, and we also find, that youth at WGYCF are not adequately protected from harm. We uncovered rampant excessive uses of force on youth at the Facility, resulting in a pattern or practice of inappropriate and disproportionate levels of force, and inadequate staff training and reporting. Force by correctional officers is unconstitutional when it is not applied “in a good-faith effort to maintain or restore discipline,” but instead is administered “maliciously and sadistically to cause harm.” Hudson v. McMillian, 503 U.S. 1, 6-7 (1992). Courts may examine a variety of factors in determining whether the force used was excessive, most commonly including: (1) the need for the application of force; (2) the relationship between the need for force and the amount of force applied; (3) the threat, if any, reasonably perceived by responsible corrections officers; and, (4) any efforts made to temper the severity of a forceful response. Id. at 7-8.

There is disturbing and strong evidence that WGYCF officers frequently and brutally react to low-level aggression from youth (e.g., abusive language or passive resistance to an order) by slamming youth head first into the ground, slapping, beating, and kicking youth. In

addition, youth are sprayed with an oleoresin capsicum agent (“OC spray”) when not necessary and in excessive amounts.

Force used by a prison official after a prisoner is subdued and an emergency has dissipated, or which is disproportionate to the force needed to regain control, violates the Eighth Amendment. Hope v. Pelzer, 536 U.S. 730, 738 (2002) (leaving a prisoner handcuffed to a pole after order had been regained constituted cruel and unusual punishment); Valencia v. Wiggins, 981 F.2d 1440, 1447 (5th Cir. 1993) (applying a chokehold on a disruptive prisoner who refused to exit the cell and striking a prisoner while handcuffed, kneeling, and non-resisting was malicious and sadistic, causing harm). The use of force does not have to result in significant injury for it to be considered excessive. Gomez v. Chandler, 163 F.3d 921, 924 (5th Cir. 1999) (concluding that there is no categorical requirement that an Eighth Amendment excessive force claim be supported by a prisoner’s significant, serious, or more than minor physical injury).

The following examples reflect disturbing incidents and evidence of correctional officers using excessive force:

- In December 2010, A.A.⁷ alleges he was asked by corrections officers to exit his cell for an unknown reason. Upon exiting, a supervisor allegedly jumped the youth and kicked him in his back four times. The supervisor then put him in his cell and another officer reportedly stomped on the youth’s left leg. In January 2011, during our tour, we observed a bruise on A.A.’s left leg that was in the shape of a boot print similar to the kind of boot worn by a corrections officer. The Facility made no report of this incident.
- In September 2010, B.B. was exiting the shower area for escort to his cell, when he reportedly was thrown against a wall and choked twice by one of the two officer escorts. Both officers reported to their Lieutenant that force was used because the youth was pulling away. The Lieutenant questioned the officers and issued a rule violation report form to B.B. for disruptive behavior. The Lieutenant did not report the incident to his supervisor. In October 2010, the Facility investigation found via the in-house security cameras and admission by the officers that the officers had used excessive force and that the Lieutenant failed to report a use of force to the next chain in command. The disciplinary action taken was unclear.
- In August 2010, a Military Training Instructor (“MTI”) in the Regimented Inmate Discipline Program (“RID”) instructed youth to prepare for a pat search. The MTI grabbed an unidentified youth by the waist of his pants and pulled until he was able to lift him from the floor by the waistband of his pants, reportedly causing the youth extreme pain. Then, the same MTI grabbed another unidentified youth by the neck, slammed him into a wall and then proceeded to choke the youth. The Facility investigation revealed that both youth were not being aggressive and did not warrant uses of force. The investigation recommended termination of the MTI, but the outcome is uncertain and there is no indication that the incident was referred to the local Sheriff’s Office for criminal investigation.

⁷ Fictional initials are used throughout the Report to preserve the anonymity of the youth.

- In May 2010, C.C. threw a liquid substance out of his cell and used profane language as an officer walked by. The officer then shouted “Open the cell door!” When questioned by another officer why he wanted the door open, the officer stated C.C. is trying to “hang himself.” The officer entered and was in the cell for two minutes when C.C. ran out of his cell, and slipped on the puddle of liquid immediately outside of his cell. The officer then grabbed C.C. from behind by his neck and dragged the youth on the ground by his neck. Another officer, observing the incident, called for assistance. More officers arrived and observed the officer, using both hands, dragging C.C. by the neck on the floor of the unit. One of the officers attempted to pull the assaulting officer off of the youth but was unsuccessful. Another incarcerated youth assisted the officer and both were finally able to pull the assaulting officer off of the youth. The investigation supported C.C.’s and witness’ accounts, and the assaulting officer admitted to grabbing and dragging the youth by the neck. He also admitted that C.C. was not acting aggressively towards him, but that he was “angry and agitated” with the youth. The Facility investigation concluded that the use of force was not justified. The officer was placed on Administrative Leave.

- In March 2010, D.D. was reportedly physically assaulted by two MTIs during two separate incidents. In the first instance, D.D. claimed the two MTIs grabbed, pushed and struck him while in his cell. The assault was allegedly unprovoked and continued until one of the MTIs received a radio call. A few hours later, as D.D. waited in the education hallway to receive instructions on his classroom assignment, one of the same MTIs instructed D.D. to stop moving, and then struck the youth underneath his chin and behind his head with an open hand. D.D. reported the incident, but the assaulting MTI did not file a use of force report. In-house security cameras in the education area corroborated D.D.’s account. The Facility Investigator made no findings concerning the assault in the cell that was not recorded by a camera. The MTI caught on camera was placed on Administrative Leave for using force that was not justified. The other MTI alleged to have struck D.D off-camera in the cell was not disciplined.

We found a pattern of instances where youth, already confined in their cells, were subjected to force beyond that which was necessary for orderly administration. In many instances, excessive force was used when youth were too slow to react to an officer’s orders or used profane language. We also found that youth were assaulted for the way they allegedly looked at officers or for absolutely no given reason at all.

3. Chemical agents are used excessively at WGYCF.

The State found, and we agree, that staff often uses Oleoresin Capsicum (“OC”) spray or “pepper spray” in excessive amounts, and as an early response rather than as a last resort, contrary to policy. More specifically, staff inappropriately used OC sprays on youth who were simply refusing verbal commands to remove their arms from the food tray flap while already in a secured locked cell. We also found that there is a lack of guidance on decontamination procedures.

a. Excessive Amounts of Chemical Agents

We found that the Facility uses excessive amounts of chemical spray. In use of force reports, staff describes using only one to two short bursts of OC spray during incidents. However, in reviewing WGYCF use of force videos, we observed a considerable amount of chemical agent being used on youth far beyond one or two short bursts. In one video, an officer used so much chemical spray on a youth, the surrounding staff, some as far as approximately 20 feet away, are seen coughing and seemingly having a difficult time breathing and seeing. Of the 300-400 youth we interviewed, an overwhelming majority described the excessive use of chemical agents. Some described instances where entire spray cans appeared to be emptied into a cell, after which the staff secured the door with the youth inside. During an interview with a Lieutenant in January 2011, he informed us that he could “barely remember the last time [he] used OC spray on an inmate” and thought it was “at least nine months ago or longer.” However, a review of use of force videos showed that same Lieutenant using OC spray on a youth on December 20, 2010, a mere two weeks before we interviewed him.

In determining whether the use of a chemical agent for controlling youth may be unconstitutional, as with any other use of force, 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, 503 U.S. at 7 (quoting Whitley v. Albers, 475 U.S. 312, 321 (1986)). Although it is well-established that the use of chemical agents on recalcitrant prisoners is not *per se* unconstitutional, there are constitutional boundaries to its use. See Iko v. Shreve, 535 F.3d 225, 239 (4th Cir. 2008) (use of additional bursts of pepper spray after inmate attempted to comply with officer's orders and which possibly contributed to inmate's asphyxiation and death sufficiently alleged objective component of excessive force claim); Soto v. Dickey, 744 F.2d 1260, 1270 (7th Cir. 1984) (“[I]t is a violation of the Eighth Amendment for prison officials to use mace or other chemical agents in quantities greater than necessary or for the sole purpose of punishment or the infliction of pain.”). We find that WGYCF does not properly evaluate the need for chemical spray and uses excessive amounts.

WGYCF officers most commonly use a chemical agent known as the “Fox Fogger.” According to the manufacturer, Fox Laboratory International, the Fox Fogger Personal Sized Duty-Belt Units do not use tiny nozzle openings that reduce the amount of formula discharged per burst.⁸ Instead, the Fox units discharge as much of their formula as possible per one-shot burst, regardless of the size of the can. Using the “Fox Fogger” is not prohibited; however, knowing that the maximum amount of OC spray is administered per one-shot burst, it is astounding to find that officers expose youth to several bursts or extended amounts of spray. Inhalation of high doses of some of the chemicals found in OC spray can produce adverse cardiac, respiratory, and neurologic effects, including arrhythmias and sudden death.⁹ Exposure to OC spray may occur through skin or eye contact, or inhalation. With acute exposure, there is a rapid onset of symptoms including nausea, fear and disorientation. Respiratory responses to OC spray include burning of the throat, wheezing, dry cough, shortness of breath, gagging, gasping,

⁸ Fox Labs International, available at <http://www.foxlabs.com/pepperspray.shtml> (last visited Mar. 5, 2012).

⁹ C. Gregory Smith and Woodhall Stopford, Health Hazards of Pepper Spray, 60 N.C. MED. J. 268, 274 (1999).

and inability to breathe or speak.¹⁰ When WGYCF officers deploy chemical agents in unnecessary and excessive quantities, this is a violation of the Eighth Amendment. Danley v. Allen, 540 F.3d 1298, 1311 (11th Cir. 2008).

b. OC Spray Used as a First Response

We found that WGYCF staff excessively uses chemical agents for minor rule violations, such as when youth “buck the flap.” “Bucking the flap” occurs when a cell door is locked, but a youth simply refuses to remove his arm from the food tray flap, which is located on the cell door. Many of the youth we interviewed indicated that they “buck the flap” when staff ignores them and that is often the only means of getting administrative, medical, or mental health care attention.

The State acknowledged that although this is a common occurrence at WGYCF, the Facility does not examine the root cause of “bucking the flap,” which we found was the youths attempt to draw the officers’ attention to an unaddressed grievance. WGYCF staff often times reacts excessively to this conduct without addressing the underlying issue. Chemical agents, use of restraints, and physical force are routinely used on youth for simply refusing verbal commands to remove their arms from the food tray flap. Staff excessively uses chemical agents even though the youth are in secured locked cells, youth are not trying to harm others or themselves, and the youth are not otherwise engaged in serious violations. These responses constitute excessive force, especially in light of the fact that the Facility’s use of force policy clearly requires that force be used only as last resort, and the Facility’s response results in unnecessary injury to youth.

In response to “bucking the flap,” WGYCF should train its staff in tactical communication and de-escalation techniques enabling corrections officers to better manage non-compliant or upset youth without the use of force. Because “bucking the flap” is not aggressive conduct, staff should investigate each incident to fully understand why the youth may be refusing the verbal command to remove his arm from the flap. In these instances, staff should seek to verbally maintain control without resorting to the O.C. spray so quickly. We found, contrary to the Facility’s policies, uses of force are not used as a response of last resort, but as early choices for staff.

For example, in September 2010, E.E. stuck his arm outside of his food portal and refused to allow the portal to be secured. After unsuccessful verbal commands, a Lieutenant deployed OC spray through the portal. E.E. was restrained and escorted to the recreation yard for decontamination and medical evaluation. The youth was placed in segregation pending disciplinary action. In another example, in August 2010, two youth refused to close their food flaps, with their arms stuck out. After verbal commands, a Captain and Lieutenant sprayed OC spray into F.F. and G.G.’s flap. Both youth retreated and were sent to the recreation yard for decontamination and medical treatment. Here, proper use of de-escalation techniques could be effective in regaining control without resorting to excessive force.

¹⁰ Id.

4. WGYCF's use of force policies, reporting, training and investigations contribute to constitutional violations.

The State acknowledged, and we also find, that WGYCF fails to provide adequate use of force policies, reporting and investigations.

a. Inadequate Use of Force Policies

The Facility's deficient use of force system, inadequate policies and procedures, reporting and investigations led to the rampant and excessive uses of force against youth.

The use of force policy for the WGYCF is addressed primarily in the Facility policy starting at chapter 9-25 and is entitled, Use of Force and Four-Point Restraint Policy.¹¹ We noted that some portions of the policy are lacking important requirements and guidance. The following are examples of the policy's deficiencies:

- requirement that photographs be taken of staff injuries following a use of force incident, but no requirement to photograph injured youth;
- no guidance provided regarding the review process for determining whether or not force was justified and reasonable;
- does not provide guidance on describing the type or amount of force used. Staff uses inadequate boiler type descriptions such as, "physical takedown" or "took the inmate to the floor" to describe use of force actions; and
- does not require that reviewing supervisors have prompt access to medical evidence such as nursing notes and anatomical drawings of the body that depict the specific areas where injuries are present following a use of force incident.

WGYCF also uses the State's Use of Force Training Policy 04-03, which provides the use of force staff training requirements. This policy does not specify the number of hours that each employee should receive on use of force regulations. Also, as discussed earlier, the policy does not provide adequate guidance to staff on decontaminating procedures when chemical agents are deployed.

b. Inadequate Supervisory Review

In addition to the staff reporting and investigation inadequacies, the Facility fails to require supervisors to review use of force reports. Most of the use of force reports we reviewed did not contain annotations indicating review by the Warden or State Deputy Commissioner. This is a very serious breakdown in the use of force reviewing process. An unchecked use of force program is a detriment to the Facility. Unfortunately, even in those few instances where the State Deputy Commissioner acknowledged review of a use of force incident, it is with a tacit

¹¹ It should be noted that GEO staff were still in the process of updating and converting their policy and procedure manual and post orders to meet the new vendor requirements. Surprisingly, MDOC is not required to approve the WGYCF operating policies and procedures.

and boiler plate non-committal statement that reads, “Use of force reported as justified and in accordance with MDOC policies and procedures.” This type of review process further exacerbates an unchecked use of force program and contributes to constitutional violations.

c. Inadequate Investigations and Investigatory Training

Similarly, the Facility’s investigation component is inadequate in protecting youth from harm and remedying staff behavior. The State found, and we agree, that WGYCF’s staff training is inadequate. WGYCF’s Facility Investigator is responsible for investigating all allegations of staff misconduct, youth violence, suicidal ideations, contraband, and youth on staff violence for the entire 1200-bed Facility; however, she has not received basic outside training for investigators. Most of the Facility Investigator’s knowledge of investigative techniques is derived from on-the-job training. As a result, her investigations are replete with errors and inadequacies. The Facility Investigator should be adequately trained to assume the role as incident investigator. Basic incident investigation training would provide the Facility Investigator with the needed tools to analyze an incident, reviewing reports, evidence, and witness statements.

The Facility Investigator’s lack of professional training contributes to inadequate reporting, and there is no assurance that investigations are conducted in a fair manner, without a conflict of interest. For example, we noted that in several use of force incidents, the Facility Investigator witnessed the incident under review and was the sole investigator.

When the Facility Investigator is absent or unavailable, the Facility’s Major assumes the Facility Investigator’s role. This is also problematic because the Major is also not adequately trained in this area and is then tasked with investigating staff members he supervises or is responsible for, again presenting conflict of interest issues.

d. Inadequate Training on Decontamination Procedures

Mississippi Department of Corrections Use of Force Training Policy 04-03 provides the use of force staff training requirements for the Facility. The policy does not specify the number of hours that each employee should receive on use of force regulations, including the use of chemical agents. Also, the policy does not provide guidance or direction to staff on decontamination procedures for a youth’s clothing, bedding and cell area where a chemical agent was deployed. Instead, the decontamination process is limited to having the youth checked by medical staff and washing the chemical agent from his face and eyes. Furthermore, staff possessed minimal knowledge about the safe use of chemical agents. Some staff were able to recount only basic facts about the use of OC spray (e.g., to deploy the spray in very short bursts; or how to hold the canister), while others could not recall any specific information from the OC spray training they received. We saw no evidence to suggest that youth are allowed to decontaminate their clothing, bedding and cell areas in the videos and in the numerous use of force reports we reviewed. In addition, numerous youth reported that they were put back into their cell with chemical agents still present on their clothing, bedding and cell areas.

e. Failure to Adequately Report Uses of Force

In many instances, uses of excessive force go unreported or uninvestigated. According to the WGYCF log, between December 2009 and November 2010, there were approximately 160 uses of force; however, it appears this log does not capture the real number of use of force incidents that are occurring at WGYCF. For example, the log does not capture the use of restraints as a reportable use of force, it does not capture all of the types of physical force used except for “physical takedowns,” and there are many other incidents that are not captured because staff failed to report the force incident. Also, according to the log, physical takedowns were not recorded prior to May 15, 2010 and the use of chemical agents was not recorded prior to May 3, 2010. When chemical agents are used, other uses of force that may have been used during the incident, including physical force and restraints, are not reported.

Between March 2009 and October 20, 2010, only 12 staff members were disciplined for use of force violations. In other allegations of staff misconduct, the Facility Investigator made no findings as to excessive use of force. This was often times due to the lack of corroborating evidence, such as when a Facility camera was not available to support the allegations of a youth and there was no other evidence or witness account to corroborate the youth. WGYCF should increase security cameras throughout the units and common areas for better visibility and evidence of incidents in the Facility.

f. Lack of Child Abuse Reporting

Further, we also find that that WGYCF is in dereliction of its duty to report child abuse when it occurs on its premises. According to the National Commission on Correctional Health Care’s Position Statement regarding “Correctional Health Care Professionals’ Response to Inmate Abuse”:

It is the duty of correctional health care professionals to ensure the clinical care, physical safety and psychological wellness of their patients. The correctional facility must have written policy and procedures regarding the detection, prevention, reduction and punishment of abuse of inmates. Separation of alleged victim and perpetrator is essential. In addition, for minors, any allegation of abuse toward a minor must be investigated under that jurisdictions’ Child Protection Agency (emphasis added).

The Facility Investigator has served in her role since March 2009 and reported that there have been no child abuse referrals during her tenure because, according to her, “youth lose their status as minors once they are adjudicated as adults.” Medical staff shared this misconception about their duty to report any incidents of child abuse. This practice is in clear contravention of Mississippi law, which requires that child abuse be reported to the appropriate agency and defines “child” and “youth” synonymously as “a person who has not reached his eighteenth birthday.”¹² There is no exception in this law for youth who have been adjudicated guilty of

¹² There are only two exceptions in the law: “[a] child who has not reached his eighteenth birthday and who is on active duty for a branch of the armed services or who is married is not considered a ‘child’ or ‘youth’ for the purposes of this chapter [Reporting abuse or neglect].” Miss. Code Ann. §§ 43-21-105 (West 2010); 43-21-353 (West 2007).

committing crimes as adults. Accordingly, WGYCF must set up a reporting procedure that complies with Mississippi law.

5. The State is deliberately indifferent to youth-on-youth violence in the Facility.

The State reported, and we also find, that WGYCF fails to appropriately supervise youth and protect them from youth-on-youth violence. WGYCF has a duty, under the Eighth Amendment, to protect its prisoners from violence at the hands of other prisoners. Farmer, 511 U.S. at 832-33; Longoria, 473 F.3d at 592. WGYCF officials can be held liable for their failure to protect a youth if they are deliberately indifferent to a risk of serious harm posed by another youth's violent acts. Cantu v. Jones, 293 F.3d 839, 843-44 (5th Cir. 2002) (affirming verdict against prison guards found to have manifested the requisite deliberate indifference when they left the door to prisoner's cell open, allowing him to escape and assault another prisoner). At a minimum, a prison official may be held liable under the Eighth Amendment for a known risk that he or she disregards by "failing to take reasonable measures to abate" that risk. See Hare v. City of Corinth, Miss., 74 F. 3d 633, 648 (5th Cir. 1996) (citing Farmer, 511 U.S. at 847); Cottone v. Jenne, 326 F.3d 1352, 1359-60 (11th Cir. 2003). Accordingly, WGYCF officials must take reasonable steps to protect youth from physical and sexual violence and to provide humane conditions of confinement. Providing humane conditions requires that a corrections system satisfy youth's basic needs, such as their need for safety. See Helling v. McKinney, 509 U.S. 25, 33 (1993) (explaining that the Eighth Amendment protects against future harm to inmates and requiring that inmates be furnished with basic human needs).

a. Youth-on-Youth Physical Assault

The State acknowledges, and we agree, that corrections officers fail to supervise youth, particularly youth known to be violent, resulting in a shockingly high rate of ongoing harm and serious risk of harm. The proliferation of shanks at the Facility and the existence of gang affiliation within the ranks of correctional staff increase the risk of harm youth face from fellow prisoners.

i. Proliferation of Shanks

During our investigation, we noted many instances where youth used "shanks," which are ordinary objects fashioned into a sharp or pointed weapon. Often, the victim required emergency medical treatment. For example, in reviewing the Facility's Serious Injuries/Emergency Transports list between December 28, 2009 and November 12, 2010, 91 youth were transported outside the Facility for emergency medical treatment due to youth-on-youth violence. This does not include youth who were involved in a violent act at the Facility and were treated at the Facility. The list is replete with transports for stab wounds and lacerations.

The following examples illustrate harm caused by youth having access to sharpened objects:

- In August 2010, a correctional officer observed five youth involved in a physical altercation, where one of the youth was observed wielding a sharpened metal object. One of the youth sustained a laceration to his right cheek and to his right eyebrow and was taken to an outside hospital for emergency treatment. After the incident, a shank was recovered that was made from a light fixture cover.
- In July 2010, after a youth was assaulted by several youth, he was escorted to medical by an officer. While on the way, the youth was again physically assaulted by another youth with a sharpened metal object. Apparently, one of the youth from the original assault was able to breach his cell locking mechanism and got out of his cell to further assault the injured youth.
- In June 2010, a youth was transported to an outside hospital after his cellmate lacerated the youth's right leg.
- In April 2010, a youth was transported to an outside hospital after his face was lacerated during an assault by several other youth.

An overwhelming number of youth reported that possession of shanks is common among youth for self-protection from other youth. During our investigation, a youth alerted the DOJ team that there was a piece of a razor blade on the dayroom floor. We located the razor blade and brought this issue to the attention of one of the high ranking Facility officials. In response, the official merely picked up the blade and disposed of it. We were told by many youth that they are allowed to keep razors in their possession for up to a week. This is an example of the lack of control over contraband in the Facility. Indeed, between August 23, 2009 and November 21, 2010 eight youth were criminally charged with possession of a sharpened object. However, youth also reported that staff does not detect shanks because youth hide them near their crotches, as staff will not search that area thoroughly.

ii. Failure to Supervise Youth Results in Youth-on-Youth Physical Assaults

The blatant lack of supervision by WGYCF officers creates an environment in which incarcerated youth reasonably fear for their safety. WGYCF's failure to supervise youth, particularly ones known to be violent, results in unconstitutional conditions of confinement where assaults between youth occur due to the lack of supervision. Cottone, 326 F.3d at 1359-60.

Further, we were informed by numerous youth that there is a significant amount of gang activity in the Facility. Youth also reported staff involvement with youth gang members and that, in fact, several staff members are actually members of various gangs and are involved in gang activity at the Facility. Surprisingly, a high ranking WGYCF official acknowledged to our DOJ investigative team that some of the Facility staff are involved in gangs. Given that knowledge, it is disturbing that the Facility allows gang members on staff despite the predictable conflicts of interest that arise between staff and youth of differing gangs. For example, we were informed by several youth that one of WGYCF's unit managers is known to affiliate with a certain gang. If youth are part of the same gang, the unit manager treats those

youth favorably. If, however, one is not affiliated with that gang, or affiliated with an opposing gang, youth reported that the unit manager commissions gang affiliated youth to brutally attack those youth, even assisting by ensuring that cells are unlocked during late hours to foster the attack. This condition in a prison is egregious, shocking, and unconstitutional. *Id.* at 1359 (explaining that a lack of monitoring and supervision of known violent inmates, which led to inmate-on-inmate violence, constituted impermissible unconstitutional conduct).

We interviewed approximately 300-400 youth and the great majority admitted they did not feel safe at the Facility. The following examples demonstrate disturbing evidence of the Prison's failure to protect youth from harm:

- In September 2010, a correctional officer reportedly opened a cell door from the control area and allowed two youth to enter another youth's cell and assault him. The victim was treated at an outside hospital for stab wounds to his right arm and to the back of his head and for a broken hand.
- In February 2010, a youth melee resulted in the stabbing of several youth, as well as other types of physical injuries necessitating treatment at an outside hospital. One of the injured youth, J.J., suffered irreparable brain damage and sustained a fractured nose, cuts and stab wounds. After J.J. was hospitalized for weeks, J.J.'s previously normal cognition resembled that of a two year old. After a State investigation, MDOC found, among many other serious operational deficiencies, that on the day of the disturbance, a female officer "endorsed the disturbance by allowing inmates into an authorized cell to fight. Officer (X) falsified log entries. Officer (Y) had written personal letters to an inmate (Z.Z.) (Gang Affiliation)." The Facility agreed with the findings and terminated the involved officer for inappropriate involvement with a youth. The Facility did not refer this case to the Sheriff or District Attorney for criminal prosecution.

b. Youth-on-Youth Sexual Assault

We also have serious concerns about the alarming amount of alleged sexual misconduct that is occurring between youth at the Facility. There is significant evidence that the Facility fails to take reasonable steps to protect youth from sexual assault. According to our investigation, between April 21, 2009 and September 7, 2010, six alleged incidents involving youth-on-youth sexual assaults have resulted in criminal referrals to the Leake County Sheriff's Office. This problem was caused by the grossly inadequate staffing of correctional officers on the unit patrolling the Facility's living areas. Under the Prison Rape Elimination Act of 2003, correctional facilities must not only have zero tolerance for sexual violence and abuse among offenders, as well as between staff and offenders, but facilities must protect their prisoners, report all incidents of rape and train their staff in responding to rape.¹³

The following examples demonstrate how these failures combine to create an environment where youth are routinely subject to sexual assault by other youth:

¹³ 42 U.S.C. § 15603.

- In August 2009, a youth reported to an officer that his cellmate physically and sexually assaulted him during the previous night. The victim reported that his cellmate began hitting him in the back and chest, demanding that he get out of bed. The victim complied and the cellmate attempted to penetrate him anally. Upon an unsuccessful attempt, the cellmate tried to force the victim to perform oral sex. The victim refused to open his mouth, so the cellmate forced the victim to stroke the cellmate's penis until he ejaculated. The cellmate threatened the victim with further physical harm, if the victim reported the incident. According to the Facility report, the victim was removed from the cell and the matter was referred to the Leake County District Attorney.
- In July 2009, a youth provided a Lieutenant a letter stating he was sexually assaulted by his cellmate. The victim reported that his cellmate put a shank to his neck and pinned the victim to his bed. Immediately, the cellmate began penetrating the victim anally. After the rape, the cellmate threatened to stab the victim if he reported the incident. According to the Facility report, the victim was removed from the cell and the medical report found sexual contact occurred, including blood by the victim's anal cavity. The matter was referred to the Leake County Sheriff's Office.
- In April 2009, a youth was in tears and reported that he had been raped by his cellmate. The victim informed staff that his cellmate told him if he did not perform oral sex on him he was going to stab him. The victim refused to perform this act. His cellmate took a sharp tool and put it to the victim's throat and then raped him. He also told the victim that if he told anyone, he would stab him or kill him, among other threats. According to the Facility report, the youth had a red mark on his neck, and abrasions to his arms, neck and face. Criminal charges were filed in this matter.

WGYCF is liable for its deliberate indifference and failure to react to known or obvious risks of harm. Farmer, 511 U.S. at 825. We find that WGYCF does not protect its youth from harm and sexual acts of violence by other youth.

6. WGYCF's inadequate staffing fails to protect youth from harm.

The State reported, and we also find, that WGYCF has inadequate staffing. The Facility has an authorized correctional officer complement of 245 staff (162 officers and 82 security supervisors). This is a reduction of the correctional officer force since GEO assumed operation of the Facility.

We found that WGYCF correctional officers are required to supervise more than one zone, particularly in the evening and early morning hours, when there are usually only two zone officers on the floor supervising four zones. This means that two officers are responsible for supervising between 128 and 256 youth. This is unacceptable and contributes to violations of youth's constitutional rights to reasonably safe conditions of confinement. See Farmer, 511 U.S. at 825.

The State found and we agree that the staff to prisoner ratio was low and makes the Facility less safe. WGYCF should conduct a detailed staffing analysis to ascertain acceptable levels, with the goal of providing more direct supervision for all youth in all of the six housing

units. At a minimum, there should be at least one housing unit officer assigned to each housing unit, on all shifts, at all times. This is in addition to the housing unit control center officer. For the special observation unit, there should at least be one officer assigned, on all shifts, at all times.

Another example of inadequate youth supervision was noted during our tour in the academic and vocational areas. Staff reported that there are usually two officers assigned to this area; however, the area contains numerous classrooms and vocational areas that are difficult to monitor by only two officers. Despite this claim, during our tour, we did not observe a single officer in the education or vocational area.¹⁴ Further complicating the supervision issue in the education area is the fact that many of the in-house security cameras located in the classrooms to monitor the youth and observe the instructor do not work.

In reviewing staffing levels, we reviewed the after-action report concerning the February 2010 melee, conducted by Cornell Companies, Inc. Following this major disturbance and the serious injury many youth sustained, it appears that the Facility made attempts to improve the operations. For example, a Security Threat Group management program was developed following the incident to better deter gang activity; however, gangs are still prevalent in the Facility, even among WGYCF staff. The auditors found that there was not enough staff on duty on the date of the disturbance to respond to the incident. However, in the wake of this report, staffing patterns have not significantly changed. Lack of staffing is exposing youth to risks of significant harm and the Facility's failure to address the risk bespeaks of deliberate indifference.

The State reported and we find that the lack of adequate staffing is severely limiting the time that youth are allowed out of their cells. The inadequate out of cell time increases stress and creates a tense atmosphere that is ripe for violence. We also found that the vocational programs have a waiting list of approximately 50 youth. This is a significant number of youth who should be learning a skill to enhance future employment opportunities. Numerous youth reported that they are eager to attend school or a vocational program, but there is not enough security available to supervise them. Consequently, youth who do not attend school due to lack of staffing are denied the opportunity for early release from the Facility that may be available when a youth obtains his GED certificate or regularly attends a vocational program.

7. WGYCF's inadequate life safety systems pose an unreasonable risk of harm to youth.

WGYCF fails to ensure adequate life safety systems throughout the Facility. We observed numerous deficiencies during our tour that endanger the life and safety of youth and staff. Numerous panic buttons were not working, and staff seemed to be unaware of the problem. Further, youth complained that the staff is not responsive when they activate panic buttons in the cells either because the buttons are inoperative or because staff ignores the call. Therefore, we conducted a test of the classroom and library emergency panic button system that the staff is supposed to use in an emergency situation. A staff member is supposed to be available to respond to uses of the panic button. However, when we pressed the panic button, no

¹⁴ WGYCF vocational areas contain dangerous work shop tools and materials, like hammers, nails and wood beams, to assist youth in learning skills in building, maintenance, and repair.

staff responded. Instead, unbeknownst to security and program staff, the entire emergency panic alarm system was not functioning in the education areas. Therefore, staff in the classrooms and library, as well as youth, had a false sense of safety and security. The Facility lacks any system to regularly check cell panic buttons for functionality. We note that the staff apparently took steps to address this problem. By the end of our tour, the Facility generated approximately 300 maintenance work orders regarding faulty cell panic buttons and associated equipment.

We also noted that youth are able to sabotage their cell locking mechanisms and get out of their cells, resulting in a serious breach of security and safety to staff and other youth. This deficiency results in a high incidence of youth-on-youth violence and severe injury to unsuspecting youth. Either the cell door locking devices are inferior or security staff is not inspecting the cell door locking mechanisms on a frequent enough basis.

During the tour, we also noted a serious problem with the emergency key control system. It appears the Facility does not have a system in place to regularly check emergency keys and locks. We conducted a mock emergency drill in one of the housing units. Staff failed to access emergency keys and were not able to promptly open a cell door manually. Such a lapse in life safety management can have harmful and even deadly consequences to staff and youth when faced with real emergencies. Conditions violate the Constitution when they pose an unreasonable risk of serious damage to a prisoner's current or future health, and the risk is so grave that it offends contemporary standards of decency to expose anyone unwillingly to that risk. Chandler v. Crosby 379 F.3d 1278, 1289 (11th Cir. 2004) (citing Helling, 509 U.S. at 33-35) (explaining an inmate need not await a tragic event before seeking relief, where he shows the condition of confinement posed an unreasonable risk of serious damage to his future health). The Facility's unsafe conditions of confinement expose youth to an unreasonable risk of harm, and are therefore unconstitutional.

B. THE STATE PROVIDES CONSTITUTIONALLY INADEQUATE MEDICAL AND MENTAL HEALTH CARE.

The State is deliberately indifferent to the serious medical and mental health needs of youth offenders, as demonstrated by their failure to ensure youth have direct access to medical and mental health care, failure to adequately assess and monitor suicidal risks, and failure to diagnosis and provide treatment for youth with serious medical and mental health needs. A corrections official's "deliberate indifference" to a prisoner's serious medical and mental health needs is a violation of the Eighth Amendment, which requires prison officials to "ensure that inmates receive adequate . . . medical care." Easter v. Powell, 467 F.3d 459, 463 (5th Cir. 2006) (citing Farmer, 511 U.S. at 832). Prison officials act with deliberate indifference when they are subjectively aware of and disregard a risk of serious harm to the inmate, including harm resulting from serious medical and mental health conditions. Monceaux v. White, 266 F. App'x 362, 366 (5th Cir. 2008) (affirming denial of State's motion for summary judgment on the grounds that prisoner's allegations supported claim that nurses were deliberately indifferent to prisoner's medical needs). WGYCF's deliberate indifference to youth's medical and mental health needs is the result of a systemic failure.

1. The State is deliberately indifferent to detained youth's mental health needs.

Hundreds of youth with serious mental illness have suffered at WGYCF in recent years without adequate care. WGYCF has a duty, at a minimum, not to be deliberately indifferent to incarcerated youth's serious mental health needs. Gates v. Cook, 376 F.3d 323, 335 (5th Cir. 2004) (upholding finding that MDOC officials demonstrated deliberate indifference to death row inmates' mental health needs). In assessing the merits of a prisoner's claim for unconstitutional denial of psychiatric care, courts take into account a number of competing considerations in order to decide whether that denial amounts to deliberate indifference of the prisoner's serious medical needs. Woodall v. Foti, 648 F.2d 268, 272 (5th Cir. 1981) (finding prisoner's allegation that he was denied psychiatric treatment while in prison constituted a valid claim under the Eighth Amendment). Such factors include the seriousness of the prisoner's illness, the need for immediate treatment, the likely duration of his incarceration, the possibility of substantial harm caused by postponed treatment, the prospects of some cure or substantial improvement in his condition, and the extent to which the prisoner presents a risk of danger to himself or others. Id.

Our investigation revealed that WGYCF has a number of youth who have a history of prior psychiatric illness or treatment and/or are presently exhibiting symptoms of suicidal behavior or serious mental illness. The Facility, however, is not providing adequate mental health care to those youth. Instead, the Facility fails to adequately assess and treat youth at risk of suicide. Medication management or "therapeutic lockdown" are the only treatments available, and those are plagued with errors. In addition, youth experience inordinate delays before receiving the basic mental health services that WGYCF does provide, and mental health staffing levels are grossly deficient. Collectively, these shortcomings evidence WGYCF's deliberate indifference to the serious mental health needs of incarcerated youth. It must be noted that most of these youth with their untreated or inadequately treated mental health problems are eventually going to be released in worse condition, and often times more dangerous, than when they entered WGYCF.

a. Deliberate Indifference to Suicidal and Mentally Ill Youth

Youth identified as potentially suicidal are not properly assessed or treated at WGYCF. When a psychological or psychiatric condition results in suicidal tendencies, it can be as serious as any physical pathology or injury. Gates, 376 F.3d at 343. Failure to take any steps to save a suicidal youth from injuring himself may constitute a due process violation. See Partridge v. Two Unknown Police Officers of City of Houston, Tex., 791 F.2d 1182, 1187 (5th Cir. 1986).

i. Failure to Adequately Assess and Monitor Suicide Risk

Suicide prevention begins when the youth enters the system. Processing, screening, and booking occur primarily at the State level, with a licensed practical nurse ("LPN") performing the initial mental health and suicide screening. Youth who are determined to be too medically or mentally ill are supposed to remain in a state mental health facility and not be transferred to WGYCF.

The Facility does not perform its own mental health screening. This is problematic for two reasons. First, cases of mental illness are often missed by the State's screening process. Second, severe mental illness typically presents itself in youth ages 16 to 22. After the State transfers youth to WGYCF, youth routinely experience extreme delays before seeing mental health staff. As a result, new cases of depression, psychosis, and bipolar disorder may develop in the interim between screening by the State and when the youth are eventually seen by mental health staff at WGYCF.

In spite of the fact that WGYCF is not supposed to house youth with serious mental health needs, WGYCF placed approximately 285 youth – nearly one quarter of its population – on suicide watch during the period of July 2010 to December 2010. A psychiatrist only performed follow-up evaluations on 7-8% of these youth.

Youth who are under suicide watch are not monitored appropriately, which is also indicative of deliberate indifference to serious mental health needs. Matis v. Johnson, 2008 WL 248556 (5th Cir. 2008) (dismissing an appeal from a denial of qualified immunity on a claim of deliberate indifference for a jail nurse who knew of youth's prior treatment for mental illness and prior suicide attempts, yet failed to properly complete the intake form and place the youth on suicide watch prior to his suicide). Once a youth is identified as being at risk of suicide, mental health staff should specify, in writing, how closely corrections staff should observe the youth. Health staff should reassess the youth frequently. Corrections staff should provide the level of observation ordered by mental health staff, e.g., close or constant observation. Generally accepted professional standards dictate that people who are on suicide watch should be observed at random 15 minute intervals. However, neither WGYCF's policies nor practices include these assessments or orders, thus making the observation of suicidal youth deficient in both policy and practice, and dangerous in operation. Our review of over 100 suicide watch sheets revealed serious deviations from this standard. The majority of the checks were not staggered and numerous entries recorded gaps between observations far greater than 15 minutes.

Medical and custody staff at WGYCF report that youth who "self-injure" are not tracked and do not require follow-up by mental health. The claimed rationale for this decision is that youth fake mental health crises to "get off the zone." WGYCF's failure to take any actions in the face of self-injury places all self-injurious youth in danger. Such gross inaction is unconstitutional. The following incidents are examples of WGYCF's failure to appropriately monitor youth who expressed suicidal ideation and were at risk of suicide:

- In October 2009, a correctional officer noted in his log that he observed A.B., who had a reported history of depression and suicidal ideation, in his cell with a rope tied around his neck, saying that he was going to kill himself. Ten days later, A.B. informed an LPN during pill call that he had cut himself and stated, "I want out of here. If I have to do this again I will." The LPN reportedly told the youth that she would take him to medical upon completion of pill call, which typically takes 5-6 hours. At the end of her pill call, she advised the oncoming nurse of the incident with A.B. Shortly thereafter, A.B. was found "cold to the touch, with rigor mortis, eyes dilated." The LPN did not initiate CPR or call paramedics.

- In December 2008, A.C., who had a prior history of suicide ideations and attempts, received notification that his two-year-old child had died in a motor vehicle accident. A.C. was “found hanging from light fixture. Color blue.” A.C. was revived and taken to an outside emergency room, and when he returned two days later, a nurse noted that she observed a “large reddened rope burn around left back of neck, looks like carpet burn.” Despite knowledge of A.C.’s history and suicidal behavior, the nurse cleared A.C. for placement in administrative segregation, as opposed to placing A.C. on suicide watch.

The medical team’s delay in responding to youth who express active thoughts of self-harm is indicative of WGYCF’s deliberate indifference to the serious mental health needs of youth.

ii. Failure to Adequately Treat Youth with Serious Mental Illness

WGYCF’s failure to treat serious mental health needs amounts to deliberate indifference. WGYCF does not provide mental health crisis services (including group therapy, one-on-one therapy, access to beds in a health care setting for short-term treatment and acute care (an inpatient level of care)); chronic care; and/or a special needs unit for youth who cannot function in the general population. Instead, medication management or “therapeutic lockdown” are the only treatments available, and even those are plagued with errors. Youth at WGYCF whose serious mental health needs are left untreated are at risk of harm, suffer unnecessarily, and may be at risk of harming others. Helling, 509 U.S. at 33-35 (1993).

The following cases illustrate that youth with very severe mental illnesses are being sent to WGYCF, contrary to State policy and procedure, and these youth then receive egregiously inadequate treatment for their illness:

- In July 2010, the Facility’s psychiatrist met with A.D., who reported a two year history of psychiatric treatment on an outpatient basis at his State screening. The psychiatrist gave a verbal order for an intramuscular medication but did not document the reason. Approximately two weeks later, A.D. met with the psychiatrist, who noted the youth was hearing voices telling him to hurt other people and that he had visual hallucinations, as well. The psychiatrist diagnosed the youth with psychosis and prescribed two new drugs. In December 2010, the youth reported that he could not sleep. The psychologist (not the licensed psychiatrist) recommended discontinuing one of the drugs the psychiatrist had prescribed and starting another drug under the “sleep protocol.” Approximately ten days later, the psychiatrist restarted the youth on the original drugs he had prescribed. Starting and stopping medication in this fashion risks worsening A.D.’s mental illness. Further, the complete absence of mental health treatment, except for medication management, for a youth such as A.D., who suffers from a serious mental illness, is unconstitutional.

- In November 2009, A.E. was referred to a “psych doctor” because correctional officers were unable to arouse him one morning. Other youth stated he had saved eight pills to take in one dose. The following day, A.E. met with the psychiatrist, but the psychiatrist did not appear to be aware of the overdose, as he made no mention of it in his notes, nor did he perform a suicide risk assessment. In January 2010, A.E. lacerated his arm with a razor blade, requiring sutures. Approximately one week later, the youth complained of mood swings and was referred to the psychiatrist, who diagnosed him with mood disorder and malingering symptoms of suicidality and prescribed him medication. A.E. cut himself an estimated five times in 2010 and was on suicide watch for five months without a mattress, underwear, socks, educational programming, or psychotherapy. Despite this, WGYCF had not provided him additional treatment.
- In August 2008, A.F., a youth with a history of psychosis and treatment with an atypical anti-psychotic medication, met with the psychiatrist at the request of corrections staff, who described him as guarded, suspicious, and often seen mumbling to himself. The psychiatrist ordered medication and placed him on suicide observation. Three days later, the psychiatrist described A.F. as, “doing fine. Assessment: Stable.” Several months later in February 2009, the youth reported, “I’m not the same without my meds,” referring to the drugs he had been taking pre-incarceration. In 2010, A.F. initiated at least three requests to be seen by a psychiatrist, but in each instance significant time, ranging from one week to two months, elapsed before he saw a mental health professional. He was also on suicide watch almost every month in 2010. Throughout his incarceration at WGYCF, A.F. has not received adequate mental health treatment services, which should have included group therapy, 1:1 psychotherapy or treatment with his prior medications.

These examples demonstrate that youth with a diagnosed history of severe mental illness are getting past State screening and sent to WGYCF, where they receive inadequate mental health services. At WGYCF, youth are routinely taken on and off medications, which is dangerous to the youth’s health, and psychologists frequently prescribe medication, which they are not licensed to do. Further, the youth languish for years at a time without receiving evidence based mental health services that are routinely used to treat serious mental health conditions. These practices evidence deliberate indifference to youth’s serious mental health needs. Monceaux, 266 F. App’x at 366 (“A prison official’s knowledge of a substantial risk of harm may be inferred if the risk is obvious. Obvious risks . . . include disregarding a doctor’s orders.”).

iii. Inadequate Suicide Prevention and Risk Training

WGYCF fails to provide adequate suicide prevention training to all corrections, medical, and mental health staff to ensure the safety of self-harming youth. Successful suicide prevention is a collaborative process among all staff; however, training is particularly critical for corrections officers because they are the only staff present 24 hours per day and who have regular contact with the youth. Pre-service and annual training requirements should be clearly set forth in the relevant policy. Training should ensure that staff is able to recognize the verbal and behavioral

signs that indicate a suicide risk, know what to do when a risk is suspected, and understand how to respond when there is a suicide attempt (generally achieved through mock drills). A qualified mental health professional should provide suicide prevention training; however, at WGYCF, it is provided by an unlicensed counselor who only had one documented hour of suicide prevention training herself that year. Suicide prevention training at WGYCF is grossly inadequate.

b. Excessive Delays in Access to Mental Health Care

Prisons must deliver mental health care in a timely manner. Unreasonable barriers must be removed, including barriers that deter youth from seeking care for their serious mental health needs, permit unreasonable delays before inmates are seen by prescribing providers, and delay sick-call appointments. See NCCHC Standard YE 07. The delay of medical care can constitute an Eighth Amendment violation “if there has been deliberate indifference that results in substantial harm.” Easter, 467 F.3d at 463.

Youth at WGYCF experience inordinate delays before receiving necessary mental health care and often have to fill out multiple requests before receiving mental health treatment. Youth we interviewed reported that once they successfully received a medical request slip from the unit manager or correctional officer, which was difficult in itself to obtain, they were forced to submit two or three slips before the sick call request was answered. As discussed earlier, they also stated that in order to get medical attention, they resorted to placing their arms outside the food port and would “buck the flap,” and frequently face being sprayed with a chemical agent or another use of force in response. The youth’s reports were substantiated in the medical records. Further, mental health grievances are not tracked for patterns, trends, or repeated issues. The Facility views weeks of delay in access to care as acceptable and considers it standard operating procedure for youth to first *request* a follow-up appointment rather than place youth on a chronic care list for routine management. This practice is contrary to generally accepted professional standards and to WGYCF policy.

The following examples illustrate the significant delays youth at WGYCF experienced before receiving mental health care, and the harm that resulted:

- In June 2010, A.G., who has a history of depression, suicide ideations and family suicide, was placed on suicide watch. He did not see the psychologist until over one week later, at which time the psychologist noted, “He is catching suicide to get off the zone.” In October 2010, the youth submitted a request for mental health treatment, “My grandma just died and I am hearing voices.” Three weeks later, he was referred to the psychologist who noted, “Mood up and down, lost 30 pounds, insomnia. Rule out bereavement. Refer for medication evaluation.” A week later, A.G. saw the psychiatrist who diagnosed, “Normal grief,” despite the 30 pound weight loss, and prescribed no medication; it is not clear whether the psychiatrist reviewed the record. In December 2010, more than two months after his grandmother’s death, the psychiatrist finally diagnosed him with “Depression and Grief Reaction” and prescribed medication.

- In May 2010, the State conducted a mental health evaluation of A.H. and noted that he had a prior diagnosis of schizophrenia and had been on and off medication for several years. At the screening, the youth complained of auditory and visual hallucinations, including hearing voices calling his name. In spite of this history and complaint, he was sent to WGYCF. In June 2010, upon arrival to WGYCF, A.H. was held “in the infirmary”¹⁵ until the psychiatrist could perform an evaluation. Three days later, A.H. was finally evaluated and prescribed medication; the psychiatrist noted that A.H. reported hearing voices in his head and feeling the devil was after him. A.H. did not see a psychiatrist again until two months later. At the time of our investigative tour in January 2011, he had not seen a psychiatrist since August 2010.
- In December 2008, A.I. submitted a psychiatric request slip, which stated: “Something in my ear is making my head hurt very bad.” An LPN documented his complaint and noted that he was hearing screaming noises, but did not refer him to the psychiatrist. Several months later, in June 2009, the youth submitted another slip, this time complaining that he was hearing voices in his head telling him he was going to die. There is no record a mental health professional met with him at that time. In February 2010, the youth complained that he could not sleep and that his depression was getting worse. It was nearly two months later before the psychiatrist met with him. In May 2010, A.I. was sent to the hospital to extract a razor blade that he used to cut his arm. In August 2010, A.I. noted he again needed his medication and that he was not receiving it consistently. He was referred to the psychiatrist one month later.

Additional cases reviewed showed a clear pattern: youth were admitted with a history of substance abuse issues and/or psychiatric treatment, developed bizarre behaviors such as flight of ideas, depression, agitation, or confusion, and were evaluated months later, usually only by a nurse. Subsequently, youth were returned back to general population due to alleged “malingering” with no mental health follow-up and sometimes became suicidal. This pattern of care evidences a deliberate indifference to serious mental health needs and is a violation of youth’s constitutional rights. Gates, 376 F.3d at 335 (noting the inadequacy of a prison’s mental health services where some inmates are medicated “but there is essentially no other mental health services” provided).

c. Staffing Deficiencies Responsible for a Lack of Essential Services

As the State acknowledges, and we agree, mental health staffing levels at WGYCF are inadequate. One psychiatrist, who was on call an average of 14 hours per month in 2010, is responsible for providing psychiatric coverage at WGYCF. This equates to a .08 full time equivalent (“FTE”) psychiatrist for a population of 1200 prisoners. That level of psychiatric staffing is shockingly low. The psychiatrist, who has no formal on-call duties, estimates that he was called at home approximately one or two times every two weeks. There are two psychologists who each work part-time on alternating weeks, once per week for five hours per day. This is the equivalent of 1.25 FTE psychologists, an equally shocking lack of mental health staff for a prison of that size. The State reported that the lack of available mental health staff

¹⁵ It is not clear what the reference to an “infirmary” means. The medical unit at WGYCF has no beds.

causes inmates to stay in the suicide observation unit for up to two weeks where they get no education, no programming, and no out of cell time while simply awaiting to be cleared from that unit.

Mental health staff fails to provide group therapy, psychotherapy, or 1:1 counseling. The Education Department provides substance abuse and anger management programming, but only to a limited number of youth (less than 10% of the general population). Youth housed within administrative segregation, on suicide watch, or designated as special needs status receive no programming at all. This practice makes no sense. The youth with the greatest need for programming and treatment do not receive it.

Given its pronounced mental health staffing deficiencies, it is not surprising that the Facility fails to provide adequate mental health services. A mental health care program for chronic conditions is a vital component of rehabilitation for incarcerated youth with serious mental illnesses, but such a program does not exist at WGYCF. Specialized programs for incarcerated youth with schizophrenia, bipolar disorder and other major mental health disorders are endorsed by not only the American Psychiatric Association, but are also required by the NCCHC standards for mental health services in correctional facilities. See NCCHC Standard J-G-04.

Other required services are also absent: identification and referral of youth with mental health needs; crisis intervention services; psychotropic medication management; individual counseling; group counseling; psychosocial/psycho-educational programs; and treatment documentation and follow-up.

The majority of the youth taking psychotropic medications were receiving minimal psychiatric follow-up. Nearly all the youth who reported suicidal ideation or attempted suicide were labeled “malingerers” and provided no further mental health support. No one inquired into what prompted the behavior nor did anyone track youth with repeated complaints of distress. The Facility cannot adequately assess whether mental health staffing levels are appropriate because it fails to track requests for mental health care and youth placed on suicide watch. We saw no evidence of a qualitative mental health review, including in cases of death/morbidity, or of routine review of medication errors and lack of access to care. These practices amount to deliberate indifference towards the serious mental health needs of youth, in violation of their civil rights. Gates, 376 F.3d at 335.

2. The State is deliberately indifferent to detained youth’s serious medical needs.

The State is also deliberately indifferent to the serious medical needs of its youth. A serious medical need is one for which treatment has been recommended or for which the need is so apparent that even laymen would recognize that care is required. Vasquez v. Dretke, 226 F. App’x 338, 340 (5th Cir. 2007). A prison official’s knowledge of a substantial risk of harm may be inferred if the risk is obvious. Monceaux, 266 F. App’x at 366. Conditions violate the Constitution if they pose an unreasonable risk of serious damage to a prisoner’s current or future health, and the risk is so grave that it offends contemporary standards of decency to expose anyone unwillingly to that risk. Helling, 509 U.S. at 33-36; Gates, 376 F.3d at 332-33.

WGYCF fails to identify and treat youth who present obvious symptoms of serious illness and injury. When WGYCF does identify youth in need of medical treatment, the treatment provided is often insufficient, placing the youth's health and safety at risk. Youth are needlessly suffering and, in some cases have even died, due to the Facility's deliberate indifference to their medical needs. Below we highlight five major areas of deficiencies: (1) intake screening and initial health assessments; (2) correctional medical care; (3) access to care for acute medical needs; (4) management of chronic health problems; and (5) failure to recognize the special duties owed to youth.

a. Deficient Intake Screening Process

Screenings and health assessments at WGYCF must be timely, thorough, and completed by competent professionals with the necessary training to identify signs that pose risks to youth's health, so as to meet the Eighth Amendment's mandate that prison officials "ensure that prisoners receive adequate ... medical care." Easter, 467 F.3d at 4463 (quoting Farmer, 511 U.S. at 832). As the State acknowledges, and we agree, WGYCF fails to conduct a proper and thorough medical examination upon intake, thereby failing to identify the acute and chronic care needs of youth entering the Facility. This failure amounts to deliberate indifference.

Our investigation uncovered that it is difficult, if not impossible, for nurses to conduct a proper and thorough medical examination of the youth upon intake because the exam rooms do not contain examination tables, chairs, or examination equipment. Youth are placed in individual "exam rooms" to wait for the physician or nurse practitioner to enter the furniture-less room to conduct their exam.

During our tour, we observed a nurse practitioner perform an examination of a youth. While an examination of the upper body was performed, there was no examination of the lower portion of the body other than pulling up pant legs and looking at the skin. A standard examination, which should include palpation and/or percussion of the thorax and abdomen and lower extremity pulses, and examination of the skin, is not possible while the youth stands in an "exam room" containing no furniture.

Further, the Medical Unit appeared to lack equipment for urinalysis and peak flow meters. These are identified in Health Assurance policy and procedures as being a routine part of the intake evaluation. Asthma is the most prevalent chronic disease in children and adolescents. A peak flow meter should be available to evaluate this disease. Dipstick urinalysis is also necessary to check for kidney disease or urinary tract infections. As a result of these deficiencies, youth do not receive a necessary assessment, which in turn, can lead to an unreasonable risk of serious damage to a youth's current or future health.

b. Failure to Provide Youth with Adequate Access to Medical Care

Youth can request medical treatment through a sick-call form. Even though the medical staff receives these sick-call complaints, we find that WGYCF fails to take timely and necessary action. This failure to act is unconstitutional deliberate indifference to youth's serious medical needs. Estelle, 429 U.S. at 104. Every one of the grievance slips we reviewed complained about access to care.

Youth are entitled to direct access to health care, but the sick-call process at WGYCF creates significant impediments to that right. If a youth wants to put in a request to obtain medical services, the youth must ask for a “sick call request sheet” from a corrections officer on duty. Most often, these request slips are locked in a box within the unit. The corrections officer must unlock the box and then give the form to the youth. The youth then returns the form to the corrections officer and hopes the officer places the request in the sick call request box. Alternatively, youth may choose to wait for nursing staff to make their rounds and hand the sick call request slip directly to the nurse. The nurse on night duty collects the sick requests each evening and is responsible for creating a list of youth to be seen, which is distributed to Facility officers in the morning.

Once the sick call requests reach the Medical Unit, there are often extreme delays in providing the requested relief. Often, the interval between requesting service and receiving service was greater than seven days. Youth routinely had to make several sick-call requests before a nurse would initially evaluate them, and then would endure extensive delays before seeing a physician, following a nurse’s referral.

WGYCF’s sick call process interposes several obstacles to youth having direct access to health care. Rather than locking the blank sick call requests forms in a box, the forms should be easily accessible and available to the youth. After the youth fill out their sick call request form, they should be able to place the form themselves in a secure locked box to ensure that it reaches its intended location. This would address youth’s concerns that correctional officers use access to sick call requests as leverage to manipulate the youth’s behavior. This might also reduce the excessive delays youth experience before receiving medical care.

The following are examples of WGYCF exhibiting deliberate indifference to the serious medical needs of youth due to excessive delays in providing medical care:

- One week prior to our investigation, A.J. filled out a request slip to be seen regarding a scalp problem. After one week, he still had not been seen.
- In December 2010, A.K. put in a medical request for evaluation of intense knee pain, but was not seen by a nurse for 8 days.
- In December 2010, A.L. requested to be seen for a spider bite, a potentially very serious problem. He was not seen until three days later.
- Youth A.M. experienced several delays:
 - In June 2010, he was seen by the physician and medication was ordered. He had to request medication three additional times before he actually received the medication.
 - In October 2010, he complained of a neck rash, but was not seen for 11 days.
 - In November 2010, he requested treatment for a head rash, but wasn’t evaluated for 10 days.

Through WGYCF's sick-call process, medical staff is made aware of youth's medical needs. Despite this knowledge, WGYCF repeatedly fails to provide timely care. This situation amounts to deliberate indifference that places youth at risk of grievous harm. Helling, 509 U.S. at 33-35.

c. Failure to Provide Adequate Care to Youth with Serious Chronic Medical Needs

Chronic care programs in correctional settings are critical to avoid placing incarcerated youth with serious medical needs at excessive risk. The requirements of chronic care are addressed in guidelines developed by the NCCHC.¹⁶ See NCCHC Standard YG 02. While WGYCF claimed to be following the NCCHC guidelines, our review of prisoner charts revealed that no chronic care program exists.

For example, our investigation revealed that WGYCF has neglected to implement a protocol to treat hypertension among the youth. During our tour, we took a random sample of the youth's vital sign data and noticed at least ten youth with multiple instances of blood pressures above 120/80 (normal value for adults). The definition of abnormal blood pressure readings is three abnormal measurements of either the systolic (top number) or diastolic (bottom number). There were no treatment plans or referrals to the physician after multiple documentations of abnormal blood pressure readings.

3. Deficiencies in both medical and mental health care.

There are several deficiencies that plague both the provision of medical and mental health services, including grossly deficient medication administration, the lack of an effective quality improvement mechanism, and physical plant issues.

a. Lack of Follow-up Care

All youth in the facility, especially those who are sexually assaulted, need to be informed of the availability and need for medical examinations and psychological counseling for any sexual incident. Sexual interactions can have medical consequences, including exposure to HIV and other sexually transmitted diseases. They may also exacerbate existing mental health problems and cause anxiety, depression or re-traumatize youth who have been subjected to prior sexual abuse.¹⁷

b. Grossly Deficient Administration of Medication

The administration of medication at WGYCF is grossly deficient and results in many youth not having access to their required medication in a timely fashion. Medication "pill" rounds occur at least twice daily. Medications are locked in a medication cart used to distribute medication directly to the youth on the unit. Medication Administration Records ("MARs")

¹⁶ It should be noted that in 2008, NCCHC elevated the requirement of a chronic care program from "important" to "essential," emphasizing the necessity of a functional chronic care program.

¹⁷ Smith, Sexual Abuse Against Women in Prison, 16 Crim. Just. at 35.

serve as documentation of medication administration. At the time of our investigation, there were many sites on the medication administration record that were empty, which indicates “missed” medication administrations. Interviews with youth revealed many instances of missed medication doses.

For example, on one “pill” round that we observed, the nurse had six medications that needed to be administered in the unit, but she was unable to locate three of the patients. Apparently, nurses are not given an updated housing unit list on a regular basis. When the nurse cannot locate the youth, the medication is not administered. This results in missed doses as well as misplaced medications. Pill rounds frequently take up to five hours because of the inability to locate youth. During this time the nurse is not available for other nursing duties.

Another problem with medication administration is that the nursing staff fails to consistently record in the MAR. Medications should be documented as soon as they are given. Often two or three youth were given medication before the nurse stopped to record the administration on the MAR.

c. Inadequate Quality Assurance Mechanism

Our investigation revealed the fundamental problem underlying the provision of medical services at WGYCF is that the Facility does not recognize that it owes a special duty to youth confined to its care. The Facility is using the wrong quality assurance standards to gauge the quality of medical and mental health services it provides, and it does not employ any medical professionals that have expertise in pediatric medicine.

Correctional facilities must have quality assurance systems in place to ensure accountability for errors that lead to grievous harm. *Helling*, 509 U.S. at 35. Health Assurance uses the NCCHC adult jail detainee standards; not the juvenile or even adult prison standards.¹⁸ As of January 2011, the average length of stay for youth offenders at WGYCF is 3.5 years. The use of jail standards is not acceptable because jail is for pre-adjudication or short stays, usually one year or much less. The youth at the Facility have been sentenced to serve much longer lengths of time.

Further, the NCCHC recognizes that the standards that should be used to treat youth are different than those that apply in an adult correctional setting. According to the NCCHC, “[a]dolescent health specialists, including medical and mental health professionals, familiar with correctional health care should be consulted in the development of correctional policies and procedures dealing with adolescent inmates.”¹⁹ Similarly, the American Academy of Pediatrics recognizes that the practice of pediatrics is intended to address the needs of people from birth to 22 years of age. Although the youth at WGYCF range in age from 13 to 22, none of the physician providers at WGYCF have training in pediatric, family medicine, or internal medicine-

¹⁸ Each policy in the Health Assurance Medical Manual delineates the National Standard the policy was based on. In each instance, the NCCHC standard that was used was the Jail Standard, as indicated by the use of “J” in front of the policy number. For example: Access to Health Care Policy is based on NCCHC Standard: J-A-01 and J-E-07.

¹⁹ NCCHC Position Statement, *Health Services to Adolescents in Adult Correctional Facilities* (May 17, 1998), <http://www.ncchc.org/resources/statements/adolescents.html> (last visited Mar. 5, 2012).

pediatrics. While it is not necessary that all staff be trained in pediatrics, there should be adolescent and young adult expert oversight. Expertise in the psychosocial and developmental aspects of adolescents is necessary to provide appropriate health care.

d. Ineffective Quality Improvement Measures

WGYCF does not have appropriate quality improvement mechanisms for either medical or mental health services. NCCHC Standard Y-A-06 requires a continuous quality improvement program in all facilities to monitor and improve health care delivered in the facility. There were two deaths at WGYCF in the 24 months preceding our January 2011 tour. While we were told that a mortality review was conducted within 30 days of each death, we were not given access to those reviews and thus, could not corroborate that information.

Even though one completed suicide and six serious suicide attempts occurred at WGYCF between January 1, 2009 and January 11, 2011, we received no copies of reviews of death and/or adverse events specific to mental health or psychiatry despite our specific request for those records. In other words, it appears that the mental health providers at WGYCF did not perform a qualitative analysis of the suicides which took place between January 1, 2009 and our visit.

The Facility's monthly statistical report documents the provision of emergency care. There was a spike in emergency department visits, hospital admissions and hospital days in the months of January 2010 and February 2010. The average number of emergency department visits between May and December 2010 was 8.3, but in January 2010 there were 17 visits and 32 in February 2010. Similarly, the total number of days youth spent in the hospital was 12 between May and December 2010, but youth spent, on average, 15 days in the hospital in February 2010. Yet, there was no documented discussion regarding the etiology of these spikes in the minutes of the Medical Audit Committee meetings for 2010. The Facility should have documented the root cause and evaluation of its practices. In addition, the Facility should formulate corrective action. Finally, the Facility should review the role of medical services and whether the medical response was effective and adequate.

Further, treatment teams do not meet to review cases at WGYCF. In fact, there was no evidence of treatment plans, informed consent, peer review, or parental notification in cases of serious injury or probable or suspected abuse/injury. While WGYCF does have a Policy and Procedure Committee, it has no input from a physician or mental health provider. Each of these findings is problematic and indicates that there is no mental health management or oversight process.

Quality improvement is well-known to be a cornerstone of a sound medical and mental health-system, regardless of the facility's size. Measurable components of care, which should be tracked on a regular basis include: access to care, continuity, safety of the environment, grievances, and timely care delivery. The fact that qualitative review of medical and mental health services is not occurring in a prison the size of WGYCF is disturbing.

e. Physical Plant Issues

There are several physical plant issues that interfere with the provision of adequate medical and mental health services. For instance, the Special Needs modules are primarily indirect supervision housing with 16 cells. The cameras operating in these cells have a significant blind spot in which a youth could easily harm himself or suffer a medical emergency (such as a seizure) outside the view of an officer. Earlier, we discussed the serious issue related to emergency call buttons. Direct supervision could be provided if correctional officers were performing rounds on an intermittent basis. However, a review of hundreds of suicide watch sheets revealed that these checks were not performed on a staggered basis, which is the standard of care.

Youth confined in segregation units experience additional obstacles in accessing adequate medical care. The medical and mental health staff perform medication management contacts on administration segregation cell-side, as opposed to in the medical unit. In the segregated units, a card for recording nurse checks is placed outside each unit near the door. The card is initialed whether the youth is seen or not. Conversations between the nurse and the youth occur through the flap in the door. This method of interviewing youth deprives them of confidentiality and may contribute to victimization, as the assessment is done from outside the cell with other youth well within hearing distance.

IV. REMEDIAL MEASURES

In order to rectify the identified deficiencies and protect the constitutional rights of youth confined at WGYCF, the State should expeditiously implement the minimal remedial measures set forth below. These measures are necessary to ensure that youth are adequately treated, protected from harm, and receive adequate medical and mental health care, including adequate suicide prevention.

A. PROTECTION FROM HARM

1. Protection from Harm by Staff

- a. Adopt and implement a zero-tolerance policy for physical and sexual abuse of youth by staff.
- b. Review hiring process and make any changes necessary to ensure the hiring of qualified staff.
- c. Develop and maintain age appropriate, comprehensive and contemporary policies and procedures regarding permissible uses of force (including among other things, de-escalation techniques and an appropriate continuum of interventions short of physical force).
- d. Expressly prohibit the use of force as a response to verbal insults or youth threats.

- e. Expressly prohibit the use of force as a response to youth's failure to follow instructions where there is no immediate threat to the safety of the institution, youth, or staff, unless corrections officers have attempted a hierarchy of documented nonphysical alternatives.
- f. Expressly prohibit the use of force as punishment.
- g. Expressly prohibit the use of punching and slapping to the head or slamming youth's heads into the ground.
- h. Ensure that all youth's allegations or staff reports of child abuse are referred to the appropriate external agency immediately.
- i. Develop and implement a process to track all incidents of use of force that at a minimum includes the following information: youth name, housing unit, date and type of incident, injuries, if medical care is provided, primary and secondary staff directly involved, reviewing supervisor, external reviews and results, remedy taken, and administrative sign-off.
- j. Provide a minimum of four 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.
- k. Provide competency-based training for all staff and the Facility Investigator responsible for conducting Facility incident investigations, including use of force allegations and sexual misconduct allegations.
- l. Ensure that incident reports contain all material information including, at a minimum:
 - i. the number of youth and staff present at the time of the incident, and the location of individuals present;
 - ii. activity that occurred just prior to the incident;
 - iii. a thorough description of the incident;
 - iv. specificity as to how staff responded and intervened; and,
 - v. witness's statements from all staff and youth present.
- m. Review all use of force and incident reports multiple times per week and document the review. Implement all appropriate remedial action.

- n. Review all youth grievances multiple times per week and document the review.
- o. Conduct routine and unpredictable audits of video recordings and surprise in-person visits to the Facility during the overnight shift and on weekends.
- p. Promptly investigate any incident where staff is suspected of possible violations of law, policies, procedures, or rules.
- q. Impose and document appropriate counseling, reprimands, training, or sanctions on staff found to have violated policies, procedures, or rules.
- r. 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 and any chemical agents), provide new employee training, and provide annual refresher training.
- s. Prohibit the use of chemical agents, except in extraordinary circumstances (e.g., when there is imminent danger to staff or others).
- t. Develop and implement policies and procedures for the effective and accurate maintenance, inventory and assignment of OC spray and other security equipment.
- u. Develop and implement an adequate system of tracking and reviewing use of force incidents. The system should be capable of identifying patterns and trends that can be addressed through training, administrative, or disciplinary measures.

2. Protection from Harm by Youth

- a. Transfer and house youth age 17 or under in the State's juvenile system, and in the absence of a transfer to a juvenile facility, those youth 17 and younger should be housed in a single unit with specialized programming and limited contact with other youth.
- b. Conduct a staff and supervisor assessment to determine the appropriate staff to youth and supervisor to staff ratios for enhanced supervision of all incarcerated youth.
- c. Ensure frequent, irregularly timed, and documented security rounds by corrections officers inside each housing unit.
- d. Ensure that staff adequately and promptly reports incidents involving youth violence.

- e. Develop a process to track all serious incidents that captures all relevant information, including: location, any injuries, medical care provided, primary and secondary staff involved, reviewing supervisor, external reviews and results, remedy taken, and administrative sign-off.
- f. Increase video surveillance in critical housing areas and adjust staffing patterns to provide additional direct supervision of housing units.

B. MEDICAL AND MENTAL HEALTH REFORMS

1. Access to Medical and Mental Health Care

- a. Ensure that sick call slips are directly and readily available to youth.
- b. Implement a corrective action plan for remediation of service delays.
- c. Track all requests for medical and mental health care.
- d. Establish a system for review of all grievances regarding medical and mental health services.

2. Youth Specific Care

- a. Consult with adolescent health specialists, including medical and mental health professionals, familiar with correctional health care in the development and implementation of correctional policies and procedures dealing with youth.
- b. Implement a policy and procedure to report child abuse of any youth less than 18 years of age that complies with Mississippi's child abuse law.
- c. Admission Screening
 - i. Provide exam tables in the exam room.
 - ii. Ensure that medical staff performs a complete examination of the youth's body during intake screening.
 - iii. Provide screenings as required by the Health Assurance Medical Services Manual and the American Academy of Pediatrics.

- d. Chronic Medical Care
 - i. Provide evaluation and treatment plans for all youth with abnormal blood pressure measurements.
 - ii. Implement an audit system to verify the provision of chronic care to youth who require treatment, with a special focus on the monitoring of hypertension.

3. Medical Administration

- a. Ensure that adequate psychotherapeutic medication administration is provided.
- b. Provide standardized storage of medication so that pharmaceuticals can be easily located.
- c. Establish a system to track medication ordering and delivery.
- d. Provide nursing with a housing move list every day.
- e. Establish a system to train and monitor accurate medication administration recording.
- f. Provide a more stringent system for date and time stamping of provider orders.

4. Quality Assurance and Improvement

- a. Develop and implement an effective quality assurance program for the Medical Unit which ensures that policies, procedures, and practices are being followed. This will require, at a minimum:
 - i. creating standards that reflect current medical and mental health policies;
 - ii. establishing a process for auditing medical and mental health practices that includes document review, interviews with youth and staff, and observation of operational procedures and programs;
 - iii. drafting a written report on the level of compliance with each quality assurance standard; and
 - iv. creating a corrective action plan to address the deficits noted by the quality assurance audits.

5. Physical Plant Issues

- a. Provide direct visuals of youth in the Special Needs modules and in the segregated units.

C. MENTAL HEALTH AND SUICIDE PREVENTION REFORMS

1. Admission Screening

- a. Revise intake procedures and forms to adequately screen incoming youth for mental health issues and for suicide risk upon a youth's arrival to WGYCF and prior to housing assignment. The intake screening questionnaire must include, among other things, inquiry regarding:
 - i. Past suicidal ideation and/or attempts;
 - ii. Current ideation, threat, plan;
 - iii. Prior mental health treatment/hospitalization;
 - iv. Recent significant loss (relationship, death of family member/close friend, etc.);
 - v. History of suicidal behavior by family member/close friend; suicide risk during prior confinement; and
 - vi. Transporting officer(s) belief as to whether the inmate is currently at risk.
- b. Incorporate mental health screening results into youth's files and implement a formal communication process between intake and classification staff.
- c. Ensure that all staff conducting intake screening is trained adequately, including regarding identification and assessment of suicide risk, and are given appropriate tasks and guidance.
- d. Ensure that intake screening is conducted in a setting that provides the privacy consistent with correctional security and which includes specific inquiry regarding whether an incoming youth is currently suicidal or has a history of suicidal behavior.
- e. Ensure that medical and mental health staff conducting screening incorporate the corrections screening information into their screening process.

- f. Ensure that all reasonable efforts are made to obtain a youth's prior mental health records and that this information, along with all WGYCF screenings, is incorporated into youth's charts.

2. Suicide Prevention

- a. Provide a minimum of eight hours of competency-based suicide prevention training as part of new employee training and four hours of annual refresher training for all correction officers, medical and mental health staff, which includes:
 - i. the environmental risk factors;
 - ii. individually predisposing factors;
 - iii. high risk periods;
 - iv. warning signs and symptoms;
 - v. the Facility's suicide prevention procedures;
 - vi. liability issues;
 - vii. a discussion of recent suicide attempts at the Facility;
 - viii. the use of a rescue tool; and
 - ix. certification in CPR and first aid.
- b. Require direct care staff to immediately notify mental health care staff any time a youth is placed on suicide precautions.
- c. Notify all direct care staff on a daily basis of all youth on suicide watch precautions.
- d. Provide a mechanism for mental health care staff to 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.
- e. Provide quality private suicide risk assessments of suicidal youth on a daily basis.
- f. Ensure that all mental health care staff within the Facility has access to critical information for youth on suicide precaution (e.g., progress notes from all treating clinicians).

- g. 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.
- h. Ensure that any youth assigned to a special housing unit or disciplinary housing receives opportunities for educational and other programming.
- i. Ensure that youth who have been identified with a high risk of suicide receive one-on-one supervision by a direct care staff with no other duties until the youth is transferred out of the Facility.
- j. Clarify WGYCF's policy regarding levels of observation of suicidal youth (e.g., constant observation, unpredictable intervals not to exceed 15 minutes, etc.) and ensure that corrections officers implement documented appropriate levels of observation.
- k. Implement treatment plans for suicidal youth that identify signs, symptoms, and preventive measures for suicide risk.
- l. Require adequate emergency intervention training for all staff who regularly interacts with youth. Enforce a policy requiring corrections officers to initiate CPR if they are the first responders to suicide attempts.
- m. Ensure that cut-down tools are readily available to staff who may be first responders to suicide attempts.
- n. Conduct adequate multidisciplinary morbidity-mortality reviews of all suicides and serious suicide attempts (i.e., suicide attempts requiring hospitalization), and implement any appropriate remedial action. A preliminary review should occur within 30 days of the incident, and a comprehensive review should occur within 30 days of the completion of a coroner's report.

3. Mental Health Care Treatment

- a. Develop and implement policies and procedures to ensure youth with serious mental health needs receive timely treatment as clinically appropriate, in a clinically appropriate setting.
- b. Ensure crisis services and acute care in an appropriate therapeutic environment, including access to beds in a health care setting for short-term treatment (usually less than ten days) and regular, consistent therapy and counseling.

- c. Ensure that mental health staff conducts documented in-person assessments of youth prior to placement in a special management unit (segregation) and on regular intervals thereafter as is clinically appropriate.
- d. Ensure an inpatient level of care that is available to all youth who need it, including regular, consistent therapy and counseling.
- e. Provide adequate on-site psychiatric coverage and psychiatric support staff in order to timely address youth's serious mental health needs.
- f. Ensure that psychiatrists provide documented diagnoses of youth.
- g. Implement an adequate scheduling system to ensure that mental health professionals see mentally ill youth as clinically appropriate, regardless of whether the youth is prescribed psychotropic medications.
- h. Ensure that mental health care staff is able to access youth medical records that are up-to-date, accurate, and that contain all clinically appropriate information.
- i. Implement policies and procedures requiring that mental health staff reviews mentally ill youth's disciplinary charges to ensure that WGYCF does not impose a significant disciplinary penalty on mentally ill youth for conduct that is symptomatic of the youth's mental illness.
- j. Ensure that WGYCF's quality assurance program is adequately maintained to identify and correct deficiencies with the mental health care system.
- k. Provide outpatient treatment, including regular, consistent therapy and counseling, to all youth who are on the mental health caseload.
- l. Provide discharge/transfer planning, including services for youth in need of further treatment at the time of transfer to another institution or discharge to the community. These services should include the following:
 - i. arranging an appointment with mental health agencies for all youth with serious mental illness;
 - ii. providing referrals for youth with a variety of mental health problems;
 - iii. notifying reception centers at state prisons when mentally ill youth are going to arrive; and

- iv. arranging with local pharmacies to have youth's prescriptions renewed.

4. Mental Health Care Housing Units

- a. Provide for appropriate housing for mental health care, including a chronic care and/or special needs unit for youth.
- b. Provide an appropriate housing unit for suicidal youth, and allow those youth to leave their cells for recreation, showers, and mental health treatment, as clinically appropriate.
- c. Remove suicide hazards from all areas housing suicidal youth or place all suicidal youth on constant observation.

5. Staffing

- a. Increase mental health staff to achieve a ratio of 1.0 full time psychiatrist or equivalent for every 75-100 youth with serious mental illness who are receiving psychotropic medication.

D. QUALITY ASSURANCE

- 1. 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, at a minimum:
 - 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. produce 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.

V. CONCLUSION

The constitutional violations outlined above are the result of the State's deliberate indifference to the welfare of youth confined to its care. The widespread and significant deficiencies at WGYCF violate the Eighth Amendment's mandate that imprisoned youth be protected from harm and provided adequate medical and mental health care. The State must take immediate measures to assess the full extent of its failed oversight with the assistance of consultants in juvenile protection from harm issues. The State must also strengthen its oversight processes by implementing a more rigorous system of hiring, training, and accountability.