U.S. Department of Justice

Civil Rights Division

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

August 6, 2007

The Honorable Robert R. Altice, Jr.
The Honorable Gary L. Miller
The Honorable Tanya Walton Pratt
The Honorable Gerald S. Zore
Executive Committee
Marion County Superior Court
T-1221 City-County Building
200 E. Washington Street
Indianapolis, Indiana 46204

The Honorable Monroe Gray
President
Marion County Council
241 City-County Building
200 E. Washington Street
Indianapolis, Indiana 46204

Re: Marion County Juvenile Detention Center,
Indianapolis, Indiana

Dear Executive Committee Members and County Council President:

I write to report the findings of the Civil Rights Division's investigation of conditions at the Marion County Juvenile Detention Center ("Marion"). On July 18, 2006, we notified County officials of our intent to conduct an investigation of Marion pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, and the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141 ("Section 14141").

As we noted, both CRIPA and Section 14141 give the Department of Justice authority to seek a remedy for a pattern or practice of conduct that violates the constitutional or federal statutory rights of youth in juvenile justice institutions.

On December 13-15, 2006 and February 20-22, 2007, we conducted on-site inspections at Marion with expert consultants in juvenile justice, special education, custodial sexual misconduct, and environmental health and sanitation. We

interviewed direct-care and administrative staff, youth, and school personnel. Before, during, and after our visits, we reviewed an extensive number of documents, including policies and procedures, incident reports, investigative reports, grievances from youth, staff personnel files, unit logs, orientation materials, staff training materials, and school records. In keeping with our pledge of transparency and to provide technical assistance where appropriate, we conveyed our preliminary findings to Marion and Marion County officials at the close of our on-site visits.

We commend the staff at Marion for their helpful and professional conduct throughout the course of the investigation. We received full cooperation with our investigation and appreciate the County and Court's receptiveness to our consultants' on-site recommendations.[1] We would also like to recognize the recent addition of Mr. Richard Curry as the Superintendent of the Marion County Juvenile Detention Center. During his brief tenure, Mr. Curry had already begun to identify areas of improvement and had identified target dates to address various concerns. We anticipate that Mr. Curry will continue these efforts to improve conditions at Marion.

In addition, we note that Marion is planning to implement a Radio Frequency Identification Device (RFID), an innovative program to monitor staff movement. The facility is also planning to install internal video cameras to supplement the existing external cameras. These changes have the potential to be positive steps toward meaningful change at Marion. Based on reports we received during our investigation, these programs should be underway in the near future.

Consistent with the statutory requirements of CRIPA, we now write to advise you of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to address the deficiencies we have identified. 42 § U.S.C. 1997b. As described more fully below, we conclude that certain conditions at Marion violate the constitutional rights of the youth. In particular, we find that youth confined at Marion are not adequately protected from harm. We also find that deficiencies in the areas of fire safety, general sanitation, and general safety pose a significant risk of disease

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[1] The facility is owned and funded by Marion County, Indiana, and operated by the Marion County Superior Court under the direction of its Executive Committee and Chief Probation Officer.

and injury to youth and staff. In addition, the facility fails to provide required education services pursuant to the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C.A. §§ 1400-1482 (West, Westlaw through July 3, 2006).

In the course of our investigation, we also reviewed allegations of custodial sexual misconduct. We find no current systemic constitutional deficiencies in this area, and commend the County for its commitment to safeguarding youth at the facility from staff sexual misconduct in the wake of the multiple sexual misconduct charges filed against staff members in 2006. County and Court officials responded vigorously after learning of those criminal charges, and exhibited strong leadership in working to alleviate the threat of continued sexual misconduct. We applaud the efforts that County and Court officials have already taken in this regard.

I. BACKGROUND

Marion is a secure juvenile justice facility built in 1989 and located in Indianapolis, Indiana. Marion is primarily a detention center, receiving youth between the ages of seven and 17 who are awaiting adjudication, or who have been adjudicated delinquent and are awaiting placement at a State facility. The facility has a capacity to hold 144 youth, including a population of approximately 30 females. The youth population at Marion fluctuates daily. On December 14, 2006, 116 youth were confined at the facility. During our tour on February 20, 2007, the facility confined 124 youth.

Our investigation of systemic conditions at Marion began following the criminal indictment of ten former employees of the facility, including Marion's former superintendent. Those employees had been charged with a total of 52 criminal counts, including child molestation, sexual misconduct with a minor, child solicitation, and official misconduct including concealing evidence and failing to report sexual child abuse.[2] We subsequently received information regarding an independent investigative report authored by the National Partnership for Juvenile Services[3] regarding conditions at the facility. That

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[2] As of this writing, charges have been dismissed against six employees, one employee was convicted, one employee was acquitted, and the two remaining employees are awaiting trial.

[3] The National Partnership for Juvenile Services is a coalition of four former juvenile advocacy organizations

report, based on a February 14-16, 2006 facility assessment, concluded, among other things, that "residents at the facility are not safe."

II. LEGAL STANDARDS

Both CRIPA and Section 14141 authorize the Department of Justice to seek a remedy for a pattern or practice of conduct that violates the constitutional or federal statutory rights of youth in juvenile justice institutions. 42 U.S.C. §§ 1997, 14141. States and their political subdivisions must provide persons confined in a non-penal context – like the youth confined in Marion who are either awaiting adjudication or have been adjudicated delinquent and not convicted of a crime – with reasonably safe conditions of confinement. See Youngberg v. Romeo, 457 U.S. 307, 315-16 (1982) (recognizing that a person with mental retardation in State custody has substantive due process rights under the Fourteenth Amendment); Bell v. Wolfish, 441 U.S. 520, 535-36 & n.16 (1979) (applying the Fourteenth Amendment standard to facility for adult pre-trial detainees); K.H. v. Morgan, 914 F.2d 846, 851 (7th Cir. 1990) (stating "Youngberg v. Romeo made clear . . . that the Constitution requires the responsible state officials to take steps to prevent [youth] in state institutions from deteriorating physically or psychologically."); Nelson v. Heyne, 491 F.2d 352, 360 (7th Cir. 1974) (recognizing that juvenile detainees have a right under the Fourteenth Amendment due process clause to rehabilitative treatment, and that "[t]he 'right to treatment' includes the right to minimum acceptable standards of care and treatment for juveniles and the right to individualized care and treatment.").[4] Such constitutionally mandated conditions include the right to be

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including the National Association for Juvenile Corrections Agencies, the National Juvenile Detention Association, the Juvenile Justice Trainers Association, and the Council for Educators of At-Risk and Delinquent Youth.

[4] See also, Doe v. Strauss, No. 84C2315, 1986 WL 4108, at *4 (N.D. Ill. Mar. 28, 1986) (unreported) ("[Concluding] that what we have here is a long elevated Fifth, Eighth and Fourteenth Amendment right decisionally recognized in this state and many others. It protects juveniles when they are placed by state action in special custody, management and control because of their homeless, their delinquent conduct, and their unmonitored living. It is a right to care, management and therapy reasonably designed and calculated to effect rehabilitation, moral restoration and proper development."

free from undue restraint and the use of excessive force by staff. Youngberg, 457 U.S. at 315-16; Nelson, 491 F.2d at 356. Youth who are placed in disciplinary isolation are entitled to certain procedural safeguards. Mary and Crystal v. Ramsden, 635 F.2d 590, 599 (7th Cir. 1980). Youth in state or local custody also have a constitutional right to be reasonably protected from harm inflicted by third parties. K.H. v. Morgan, 914 F.2d at 851.

Youth in state custody also have a constitutional right to adequate fire and occupational safety. French v. Owens, 777 F.2d 1250, 1257 (7th Cir. 1985); Duckworth v. Franzen, 780 F.2d 645, 655 (7th Cir. 1985) (stating "[p]rison fires . . . are common and both their hazards and the necessary precautions well known.") (abrogated on other grounds as noted in Haley v. Gross, 86 F.3d 630 (7th Cir. 1996)). In addition, youth in State or County custody are constitutionally entitled to "life's necessities," including adequate shelter, sanitation, clothing, and hygienic materials. Gillis v. Litscher, 468 F.3d 488, 493 (7th Cir. 2006).

The State and County are also obliged to provide special education services to youth with certain disabilities pursuant to the IDEA. 20 U.S.C.A. §§ 1400-1482 (West, Westlaw through July 3, 2006). As described below, the County has fallen short of these constitutional and federal statutory obligations.

III. FINDINGS

We find that Marion fails to adequately protect youth in its care from harm and serious threat of harm, fails to provide adequate fire safety and environmental health conditions, and fails to provide youth with required special education services.

A. INADEQUATE PROTECTION FROM HARM

Youth at Marion are not adequately protected from harm because youth are subjected to excessive levels of youth violence, excessive and improper seclusion practices, inadequate suicide prevention measures, a dysfunctional youth grievance process, and an unreliable child abuse reporting and investigations system.

1. Youth Violence

Youth in institutions have a constitutional right to be reasonably safe from harm inflicted by other youth. Facilities must maintain sufficient structures, safeguards, and staffing to

ensure reasonable safety. Our investigation revealed an unacceptably high rate of youth violence, and a serious danger of continuing and intensifying physical harm at the facility.

Nearly all of the youth interviewed by our consultants reported that they do not feel safe at Marion. We found unacceptably high levels of youth-on-youth assaults, and grossly inadequate safeguards to prevent and mitigate such violence. Indeed, DOJ staff and consultants witnessed, first hand, three youth assaults during our investigatory tours. Disturbingly, youth are routinely involved in incidents requiring emergency room treatment. Violent incidents at the facility requiring "code blue" or emergency response team intervention occur daily. For example:

- On February 11, 2007, two youth [SX][5] and [JN] were involved in a fight in the gym, resulting in lacerations requiring treatment in a local emergency room. The incident report suggests that a lack of staff support may have exacerbated the severity of the injuries.

- On January 3, 2007, two youth were involved in a fight. One of the youth, [BN], required medical attention for a bloody nose. After repeated attempts to summon medical staff to the unit, a staff person went to the clinic to find the nurse. Both nurses had their coats on and were preparing to depart, without any intention to deliver the requested medical care. Ultimately, the nurses assessed the youths' injuries, and ordered treatment for [BN] at the local emergency room.

A variety of factors contribute to the violent conditions at Marion, including inadequate staffing levels, inadequate staff training, inadequate youth programming, an inadequate behavior management program, and an inadequate housing classification system.

a. Inadequate Staffing Levels

A significant factor contributing to the high levels of youth-on-youth violence at Marion is the absence of sufficient numbers of staff to adequately supervise youth. Without adequate levels of trained staff on duty, it is not possible to respond in

[5] To protect the youths' identities, we use fictitious initials throughout this letter. We will separately transmit to counsel for Marion County a schedule cross-referencing the fictitious initials with youths' names.

a safe and timely manner when violence and other crises occur. Moreover, without adequate numbers of qualified staff, detention officers do not have the time to build the relationships with youth that are necessary to identify and preempt potential conflicts.

Of the staffing sampling reviewed by our consultants for 2006 and 2007, we determined that during waking hours, approximately 80% of the units were staffed substantially below generally accepted professional standards.[6] Specifically, the 16-bed units were typically staffed with a single dedicated staff person, or a 1:16 staff-to-youth ratio. Such staffing levels during waking hours are dangerously inadequate, and make it difficult for staff to prevent and quickly intervene in youth assaults.

Indeed, incident reports were full of examples in which a single staff person was tasked with separating multiple youth involved in assaultive behavior. In one example from January 2007, a lone staff person was required to separate multiple youth involved in a fight. In an example from February 2007, a lone staff person required the assistance of three youth in order to restrain two fighting youth until additional staff assistance arrived. As one staff person so aptly reported to us during an interview, “there are 16 of them, and I only have one set of eyes.”

b. Inadequate Staff Training

In addition to adequate numbers of staff, generally accepted professional standards require that facilities provide staff with adequate training in behavior management, de-escalation techniques, assault intervention, and use of force. That curriculum should be included in both staff pre-service training, and in the required annual in-service training. A lack of training in these areas hampers the staff’s ability to diffuse tensions, discourage and prevent violent incidents, and safely and appropriately intervene once an assault has occurred. Staff at Marion do not receive adequate levels of training, and, in fact, receive no pre-service instruction in the use of force

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[6] Generally accepted professional standards typically require one direct care staff to every eight to ten youth during waking hours, and one direct care staff to every 16 to 20 youth during sleeping hours. At certain facilities, additional factors, such as poor facility layout, may require additional staff.

continuum. This lack of training contributes significantly to the violent conditions at the facility.

In November 2006, Marion contracted with a private company to provide eight hours of in-service training with all staff on "Critical Movement Intervention." This program included training on verbal de-escalation, positive interactions, and physical restraint techniques. The program lacked any formal assessment of whether staff had learned the material or techniques, and generally appeared to be inadequate to provide staff with essential skills.

The gross inadequacy of training at Marion is highlighted by our interview with several staff who were unable to articulate what they had learned or how they would apply their training in a real-world setting. In addition, a review of incident reports revealed that staff were unable to specify types of interventions, and appeared unfamiliar with basic use of force terminology.

The amount and effectiveness of staff training at the facility is a substantial departure from generally accepted professional standards. Indeed, the paucity of training opportunities means that staff are not adequately equipped to prevent or intervene in physical altercations and to protect youth from harm by others.

c. Inadequate Youth Programming

The amount and quality of structured daily programming in juvenile facilities has a significant impact on the rate of violent and antisocial incidents. Simply stated, youth who do not have adequate opportunities to engage in programmed activities become bored, and are more likely to become involved in mischief or assaultive behavior. Generally accepted professional standards mandate that youth in juvenile justice facilities receive a minimum of one hour of large muscle activity per weekday, two hours of large muscle activity per weekend day, educational programming during weekdays, and other structured developmental and rehabilitative activities. Inadequate youth programming at Marion contributes to the high levels of youth violence, and departs substantially from generally accepted professional standards.

Youth at Marion generally receive only 40 minutes of large-muscle activity per day. Some youth in isolation or in various other disciplinary categories do not receive educational services

of any kind. Other types of programming are scarce, and youth spend a significant portion of their day watching television. Youth reported that they are bored, particularly on the weekends. Detention officers reported that low staffing levels prevent meaningful programming at the facility.

d. Inadequate Behavior Management Program

Generally accepted professional standards require that facilities confining youth provide effective behavior management systems in order to encourage appropriate behavior and discourage violent or disruptive behavior. Effective behavior management systems generally involve incentive-based programs for promoting appropriate behavior throughout the day, and clearly defined guidelines that are consistently applied within the facility. For youth identified as having behavioral problems, behavior management programs should be coordinated with a treatment plan. The behavior management program should be based on proven techniques and focused on achieving lasting change through the integration of evidence-based (or scientifically measurable) outcomes. Facilities must continuously track behaviors of their youth with behavior problems and adjust their behavior management programs, when necessary, to achieve desired results.

The behavior management program at Marion is poorly structured and inadequately implemented. The range of rewards and sanctions under the program are not adequate to deter aggressive youth behavior, and therefore contribute significantly to the high levels of violence at the facility. In addition, staff are not fully aware of the features of the program, and staff and youth interviews indicate that the program is inconsistently applied. For example, when asked what the maximum number of points they could award a youth on a given day, staff reported vastly different answers. The policy regarding reward points is not clear and comprehensive. In addition, the penalties available under the system for misbehavior are limited and ineffective.

e. Inadequate Housing Classification

The absence of an adequate classification system guiding youth housing assignments contributes to the high frequency of youth-on-youth assaults at Marion. Generally accepted professional standards require that youth be housed and supervised in accordance with their housing classification status. Reliable classification systems take into consideration such information as a youth’s age, committing offense, physical

size, maturity, history of institutional violence and escape attempts, known enemies or rivals, and gang membership or affiliation. In addition, reliable systems are objective, and validated using historical facility data.

Marion does not use any type of objective classification instrument. Housing at the facility is based primarily on age. Youth of all different sizes, levels of maturity, histories of aggression and violence or other predatory behavior are all housed together, with no distinction between those who are potentially vulnerable and those who are demonstratively predatory. The current subjective housing assignment system at Marion is a substantial departure from generally accepted professional standards.

2. Use of Isolation

Marion's isolation practices substantially depart from generally accepted professional standards. Marion's use of isolation is excessive and lacks essential procedural safeguards.

a. Inappropriate Use of Isolation

Isolation at a juvenile detention facility should be used only to the extent necessary to protect youth from harm to themselves or others, or to maintain institutional discipline. Generally accepted professional standards prohibit the use of excessive isolation. Punitive isolation,[7] if used at all, should be used in conjunction with a continuum of interventions, beginning with techniques such as verbal re-direction and loss of certain privileges. Facilities are required to provide isolated youth with certain services and programming, such as medical care, mental health care, daily exercise, and to the extent reasonably possible, educational services. The length of

[7] Juvenile justice institutions typically place youth in isolation for two different reasons. Punitive or "disciplinary" isolation involves placing a youth alone in a locked room as a sanction or punishment for negative behavior for a pre-determined period of time. A separate form of isolation involves placing youth who pose an immediate and continuing threat to themselves or others alone in a locked room in order to prevent immediate self harm or harm to others. Sometimes this latter form of isolation is called a "cool down" and should only last as long as the youth continues to pose an immediate threat, and is therefore necessarily indeterminate in duration.

punitive isolation should be proportional to the offense committed.

Prior to February 15, 2007, Marion used three forms of isolation: "DOE" (an orientation phase requiring an initial three days in isolation upon admission to the facility), "Re-DOE" (essentially a return to the orientation phase), and "2H" (punitive isolation lasting from four to seven days). On February 15, 2007, the new superintendent issued a memo abolishing DOE, Re-DOE, and 2H, replacing them simply with punitive isolation lasting from two to 24 hours and requiring different levels of approval at each increment.[8] Regardless of the name used to describe it, the facility excessively relies on isolation as a means of attempting to control youth behavior. Based on the review of housing assignments in January and February 2007, on any given day, approximately 15 to 20 percent of the youth population was in some form of isolation.

In addition, staff at Marion have historically failed to distinguish violent and dangerous rule infractions from less serious disruptive or annoying behaviors. For example, our review of incident reports revealed that the vast majority of staff recommended isolation as the sanction for rule violations, together with a reduction in the youths' behavior management level. These recommended sanctions were generally the same whether the alleged misbehavior included failing to follow instructions, refusing to take a shower, or stealing food, as well as more serious misbehavior such as threatening staff, assaulting another youth, or destroying property. Punitive isolation should never be the sole response to misbehavior in a juvenile detention facility.[9]

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[8] At the time of our most recent tour in February 2007, the new isolation policy had been in effect for only three days. Therefore, there was an insufficient sampling to fully evaluate the program's effectiveness or implementation. However, the new policy appeared to be severely flawed, suffering from illogical, redundant, and overlapping guidelines, a lack of procedural safeguards, lack of staff training in the new policy, and unclear and disproportionate durations of isolation. In addition, the new policy failed to provide meaningful alternatives to the use of isolation.

[9] Examples of other generally accepted disciplinary sanctions short of isolation include letters of apology, essay writing, community service, probated sanctions, and loss of certain privileges.

The facility also fails to provide isolated youth with certain required services. For example, youth in isolation do not regularly receive mental health care services, special education services, regular access to medical care, or daily large muscle exercise. Failure to provide youth in isolation with essential services creates an additional impermissible form of punishment.

b. Lack of Procedural Protections

Generally accepted professional standards require that youth placed in punitive isolation receive notice of the charges, a hearing before an independent decision-maker, and an opportunity to present evidence in their defense. Marion fails to provide these important procedural safeguards in imposing punitive isolation. At the facility, a supervisor is required to review and approve the use of isolation. However, there is no formal process for the youth to be notified of the charges and their rights, to dispute the charges, to present exculpatory evidence, or to receive consideration from a neutral decision-maker. One predictable consequence of this failure is that Marion youth perceive the disciplinary process to be unfair and arbitrary.

3. Suicide Prevention Measures

Juvenile justice facilities must protect youth from self-harm. Youth in detention settings, like the youth at Marion, are at a much higher risk of suicide than their counterparts in the community. For reasons set forth below, Marion fails to provide adequate protections for potentially suicidal youth.

Generally accepted professional standards require facilities to screen youth upon intake for suicidality using a validated and developmentally-appropriate suicide risk instrument. In addition, staff must be trained to identify warning signs in youth after intake, and to make appropriate referrals to a qualified mental health professional ("QMHP"). Youth identified as potentially suicidal must be subject to a number of precautions, including heightened staff supervision, recurring contact with QMHPs, suicide resistant housing, and frequent staff searches for any restricted or dangerous items.

Generally accepted professional standards also require that, depending on the severity of the risk, QMHPs may order heightened supervision from a continuum of close observation, generally four randomly-timed (unpredictable) checks per hour, to one-on-one constant supervision. After a youth has initially been

identified as potentially suicidal, only a QMHP may remove that youth from precautions, or lower the level of precautions for that youth. Youth on a high level of suicide precautions should be gradually "stepped-down" to lower levels, rather than being abruptly removed.

Marion's policies and practices regarding suicide prevention are inadequate to protect youth from self-harm. Staff conduct periodic welfare checks in predictable intervals. Moreover, the existing policy fails to provide for welfare checks during waking hours. Additionally, the facility fails to adequately document or preserve evidence that welfare checks are performed. For example, Marion was unable to produce youth observation forms for any of the 15 youth on suicide precautions we requested.[10] Youth Counselors at Marion routinely make decisions regarding precautions and treatment of suicidal youth, rather than QMHPs. In addition, youth on a high level of precautions are sometimes abruptly removed, without any step-down.

Staff at Marion receive only minimal training in suicide prevention and intervention, and staff routinely ignore warning signs and act inappropriately in response to suicidal ideations, gestures, and attempts. Most staff were unable to articulate how they would respond if they observed a youth hanging, and were unaware if the facility had a cut down tool.[11] One recent example demonstrates numerous failures to implement an adequate suicide prevention system over a period of several months:

- On June 25, 2006, a youth [EL] tied a sheet to the sprinkler head in his room and was attempting to tie it around his neck when staff intervened. [EL] was not assessed by the Youth Counselor until five days later, on June 30th, when he was placed on pink card status,[12] but was then removed from suicide precautions on July 5th. On July 7th, [EL] again tried to hang himself using a sheet, and in response he was

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[10] Although some staff and youth reported that observations were being recorded on observation forms, we were unable to corroborate this with any documentary evidence.

[11] Cut down tools are specialty blades used in correctional settings to quickly cut down hanging inmates. These tools are specially designed to minimize the danger that the blade will be used as an improvised weapon.

[12] Pink card status requires staff at Marion to record observations of the youth every 15 minutes during sleeping hours.

> placed back on pink card status. Despite being on a supposedly enhanced level of supervision, the next day he attempted to tie a sheet around his neck twice, and attempted to place his head in a sink full of water. Finally, he was transferred to a psychiatric hospital on July 8th.
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> Later in the month, [EL] returned to Marion from the hospital. On July 22nd, staff observed him banging his head against the wall on two separate occasions. On July 24th, the youth verbalized a plan to jump off the second tier of the unit. On July 28th, the youth actually jumped off the tier. The Shift Manager "advised [EL] of the negative consequences of his behavior." On July 29th, the youth jumped from the second tier again, this time with a sheet tied around his neck, and "was informed he would receive additional discipline." On July 31st, [EL] tied a shirt around his neck and, in a separate incident, placed his head in a sink full of water. Another round of similar incidents occurred in November 2006. For the July 31st and November 2006 incidents, there was no record that [EL] was seen by a QMHP or that a safety plan was created to prevent him from hurting himself. Further, observation forms could not be produced for any of these time periods, and thus the facility cannot demonstrate that the youth received any enhanced supervision in response to these repeated serious gestures.

Marion also fails to protect suicidal youth from environmental hazards or contraband. The facility fails to reasonably ensure that the youths' environment and person are free of items that could be used in self-harm attempts. Staff do not receive clear instructions on what items a suicidal youth may possess. For example, in February 2007, a youth [UK] was on cautionary status after stating his intent to kill himself. On two different occasions, he was found with a length of string in the padded room in which he had been placed. For a second example, in January 2007, a nurse determined that all of another youth's [TU] belongings and clothing should be removed to protect the youth's safety. The nurse returned to the unit two hours later to find that staff had given [TU] all of her belongings back.

4. Grievances

The dysfunctional grievance system at Marion contributes to the facility's failure to ensure a reasonably safe environment.

An adequately functioning grievance system ensures that youth have an avenue for bringing serious allegations of abuse and other complaints to the attention of the administration. It also provides an important tool in evaluating the culture at the facility, and alerting the administration about dangers and other problems in the facility's operations.

Youth should have timely access to the grievance system, and grievances should be reasonably confidential. Grievances should be tracked, audited, and periodically reviewed by senior management in order to identify patterns and problems. Grievances should be responded to in a timely manner, and youth should be informed about how their grievance was resolved. Although Marion has invested in technology to improve the grievance process at the facility, the system remains a substantial departure from generally accepted professional standards.

First, the Marion grievance system relies heavily on five "Student Concern Phones" located outside of the youth housing units in certain common areas of the facility. Several youth, particularly those in isolation or restricted housing, complained that the Student Concern Phones were not accessible to them, or that limited staffing in their units inhibited their ability to access the phones.

Second, although the Student Concern Phone is an important tool in Marion's grievance system, youth should also have additional avenues for reporting concerns or allegations. For example, youth witness statements in incident reports should provide an additional avenue for reporting staff misconduct or abuse. Youth at Marion do not have the opportunity to provide written statements in connection with an incident. Currently, staff interview youth involved in an incident, and then write a summary of the youth's statement on the incident report. This practice creates the possibility that staff may, purposefully or inadvertently, misrepresent or misinterpret the youth's statements. While the current practice may be appropriate in certain situations where youth lack the ability to write, youth should first be offered the opportunity to complete their own statement.

Third, the Marion grievance system also violates generally accepted professional standards because youth are often not informed of how their particular grievance was resolved. For example, when a grievance is determined by a Marion administrator to be unfounded or not grievable, the administrator fails to

inform the youth. One obvious consequence of the lack of follow-through is that youth lose confidence that their grievance has been reviewed or given serious consideration.

5. Child Abuse Reporting and Investigations

a. Mandated Reporting

Generally accepted professional standards and State law[13] require personnel at Marion to report all allegations of child abuse to appropriate external social services and law enforcement agencies. Personnel must report all allegations, and may not filter reporting of the allegations based on the perceived credibility of the youth, or merit of the allegations.[14]

Professional standards also mandate that once an allegation of child abuse has been received, management must restrict the accused staff member from contact with youth, pending the outcome of the referral and investigation.

Marion practices substantially depart from professional standards. Supervisory personnel at the facility routinely fail to report allegations that they subjectively determine not credible.[15] In addition, because the allegations are often not determined to be credible, the accused staff are not subsequently placed on non-contact status pending the investigation. For example, the following incidents did not result in any external

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[13] See Ind. Code §31-33-5-1 ("an individual who has reason to believe that a child is a victim of child abuse or neglect shall make a report as required by this article.").

[14] Social service and investigative agencies routinely "screen-out" child abuse allegations based on lack of credibility or evidence. Staff at these agencies provide an objective and non-involved perspective on the merit of the allegations, and are specifically trained in investigating allegations of abuse. Conversely, investigations by Marion personnel do not share these qualities.

[15] It is noteworthy that the former facility director has been criminally charged for failing to report allegations that a female youth in his charge was raped by a staff person. The former director has publicly indicated that he did not report the allegations because he did not perceive the allegations to be credible. As of this writing, the former superintendent is awaiting trial.

reporting, and did not result in any attempt to remove the accused staff from direct youth supervision:

- During our second tour, a youth reported to us that a Youth Manager had sprayed him in the face with bleach in response to his misbehavior the day before. The youth indicated that one of the facility supervisors talked to him about what had happened and that he [the youth] reported the incident as he reported it to us. The youth also stated that he was not seen by medical staff following the incident. We located the incident report, and indeed, the supervisor recorded the youth's allegation that he was sprayed in the face with bleach. We were told that the incident was not forwarded to Child Protective Services because staff did not believe the allegation was true, indicating that because the youth "could open his eyes" after the incident, the episode could not have happened.

- An incident report from mid-February 2007 indicated that a staff person observed a youth with a bloody nose say to another youth, "staff hit me and you are going to be my witness." The reporting staff felt that the instruction to the other youth was evidence of collusion and that the youth with the bloody nose was lying about what occurred. The youth was disciplined "for trying to get staff in trouble." There was no record of the youth receiving any type of medical treatment.

- Two different youth called the Student Concern Phone alleging that a particular staff person threatened to harm them in separate incidents. While a single allegation should have been sufficient to trigger a report to Child Protective Services, the fact that the reported threats were so similar ("I'm going to slap the shit out of you!") is additional cause for concern. These threats were not reported to Child Protective Services, and disciplinary action amounted to telling the staff person that "she should not play this way with any student as she makes herself an easy target."

b. Facility Internal Investigations

Certain allegations of staff misconduct, including allegations of child abuse screened-out or found unsubstantiated by external agencies, should nevertheless be investigated internally for misconduct that does not rise to a criminal level. Marion recently implemented an internal facility-based

investigatory process to gather evidence and review employee conduct. At the time of our tour in February 2007, the facility had conducted one such investigation.

The resulting investigative report revealed a number of significant inadequacies in the internal investigations process. Specifically:

- Factual errors (e.g., the report indicates that a single medical staff person received the allegation from the youth, but the various attachments reveal that the youth reported the incident to at least three other staff).

- Failures to interview key witnesses (e.g., the accused staff person provided a written statement but was never interviewed; the youth reported that two other girls, since released from the facility, were also mistreated by the accused staff person, but they were never interviewed; the staff members who received the allegations provided written statements but were never interviewed).

- Poorly written narrative (e.g., several unclear references, poor grammar, spelling and punctuation errors, not well organized so the flow of information is difficult to discern).

A properly functioning internal investigation system is essential to ensure that staff are held accountable for any policy violations or provided with any additional necessary training or re-training, and that youth are treated appropriately.

B. FIRE SAFETY AND SANITATION

The environmental health and safety conditions at Marion pose a significant risk of disease and injury to youth and staff. We identified deficiencies in the areas of fire safety, general sanitation, and general safety.

1. Fire Safety

We identified several deficiencies in Marion’s fire suppression and evacuation systems and procedures. For example, Marion does not adequately conduct or document fire drills. Fire alarm boxes are key activated, as opposed to manually pulled, but not all employees have keys to the alarm boxes to activate the fire alarm system. Delays in fire notification can have deadly

consequences. We found very heavy lint and dust accumulation on all surfaces in the main laundry room. High concentrations of lint and dust can create explosive fire hazards around electrical equipment, such as washer and dryer motors. Additional fire safety hazards include a blocked emergency exit door; fire extinguishers not properly secured to the wall; an overloaded electrical receptacle holding nine devices; missing sprinkler heads; and surge protectors connected in a series. These conditions present numerous scenarios for harm to youth and staff.

2. General Sanitation

The laundry facilities do not adequately clean and sanitize youths' clothing, which increases the risk of transmitting infectious diseases, such as methicillin-resistant *Staphylococcus aureus* ("MRSA")[16] and scabies, a pruritic rash caused by the skin mite *Sarcoptes scabiei*. Youths' laundered clothing often is returned to them wet, which indicates that dryer temperature settings and/or time cycles are insufficient to ensure the destruction of pathogens, including MRSA, and results in an increased risk of disease transmission through the sharing of contaminated clothing. Youths' laundered clothing is also transported in the same laundry carts that are used for soiled clothing, which further exacerbates the risk of disease transmission.

Numerous mattresses, pillows, and safety mats were worn or torn and could not be adequately cleaned and sanitized. Mattresses and pillows in this condition can easily aid in the transmission of bacteria and diseases such as scabies and MRSA.

Youth are further at risk of disease transmission through Marion's practice of requiring youth on most housing units to share a single bottle of roll-on deodorant on the unit. This practice may be contributing to the spread of scabies in the facility. The *Sarcoptes scabiei* mite can be transferred person-to-person by sharing the same deodorant bottle.

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[16] MRSA is a virulent staph infection that thrives in close populations such as juvenile justice facilities, prisons, and medical facilities. MRSA is resistant to traditional antibiotics, and can cause severe reactions, usually after a strain of bacteria enters the body through an opening or break in the skin. An untreated infection of MRSA can cause swelling, boils, blisters, fever, pneumonia, bloodstream infections, and eventually loss of limbs and even death.

Marion's shower areas in the housing units are not adequately clean. Some housing units had fly infestations in the shower drains, which may exacerbate bronchial asthma in susceptible populations and indicate inadequate sanitation. Some shower areas had peeling paint and mold and mildew growths on the walls. Peeling paint increases the risk of bacteria and mold growth. Building dampness or moldiness has been linked with respiratory health problems such as cough, wheeze, and asthma exacerbation. Respiratory health risks may become particularly high when such fungal growth occurs inside a building.

3. General Safety

Chemical safety was also inadequate at Marion. For example, we observed numerous instances of unsecured, unsupervised chemicals, including bleach, in housing and education areas. This poses a significant risk of harm to youth and staff through accidental or intentional spills. Additionally, chemicals were not accompanied by accurate Material Safety Data Sheets ("MSDS"), and some chemicals had no MSDS sheets. In one instance, an unidentified chemical in a five-gallon container was being used to prop open a door. Without MSDS sheets, personnel may not be able to adequately respond in case of chemical exposure or other chemical-related injury.

Marion also places youth at risk of accidents by creating unacceptable safety hazards. For example, the seats on the small, four-seat fixed-metal tables in five housing units were broken, exposing the sharp metal seat mounts. This poses a very serious risk of accidental or intentional harm to youth. A trip or fall in the area of the table could produce a fatal injury if someone's head struck the seat mount. The seat mounts could also be used as weapons to inflict youth-on-youth injury.

C. SPECIAL EDUCATION

Youth with certain disabilities have federal statutory rights to special education services under the Individuals with Disabilities Education Act. In states that accept federal funds for the education of youth with disabilities, such as Indiana, the requirements of the IDEA apply to juvenile justice facilities. See 20 U.S.C. 1412(a)(1); 34 C.F.R. § 300.2(b)(1)(iv). Marion violates the IDEA by failing to adequately deliver required special education services and by denying access to any educational services to certain youth.

1. Special Education Program

Even when youth have access to the education program, the special education program is inadequate.

a. Screening

The facility appears to be under-identifying the number of youth who are eligible for special education services. Of the 124 youth in custody during our February 2007 visit, only 30 were identified as eligible for special education services.[17] This is 24 percent of the youth population, which is significantly lower than the 40 to 60 percent which, in our consultant's experience, are commonly identified in juvenile detention and correctional facilities.

b. Education Staffing

Marion has one special education teacher. Even with the relatively low number of identified eligible youth, it is unlikely that a single special education teacher could provide the services required by their Individualized Education Programs ("IEPs"). Special education youth at Marion are served in Regular Class settings (served in a special education setting for 0-20% of the school day), in a Resource setting (served in a special education setting for 21-60% of the school day), or in a Separate Class setting (served in a special education setting for more than 60% of the school day). A single teacher is simply not able to provide for the diversity of needs among the youth population at a relatively large detention facility like Marion. Even with the currently small number of identified eligible youth, at some point, the single teacher's class size would exceed generally accepted professional standards.[18]

c. Individualized Education Plans

The IDEA requires that each youth qualified for special education services have an Individualized Education Plan, and describes the IEP components required to ensure that each youth receives adequate special education services. 34 C.F.R. §§ 300.346, 300.347. The 30 youth identified as eligible for special education services at Marion had IEPs that were prepared before their detention at the facility. However, Marion fails to ensure that these IEPs are updated and appropriate for each youth. Neither the Director of Alternative Education for Indianapolis Public Schools nor the school principal could remember a single situation in which a youth's IEP was outdated

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[17] Nineteen of these youth were enrolled in school; an additional 11 youth were eligible for special education services, but had not been enrolled.

[18] The acceptable class size will vary based on the needs of the youth, but generally ranges from ten to twenty students per class.

and required a case conference to make it current. However, a review of just five randomly selected IEPs revealed several in which the IEP appeared to be expired at the time of admission, yet MDJDC had taken no action to review or update the document.

- One youth [UK] was in custody from January 11 through March 8, 2007, or 40 school days. The youth's previous IEP had expired approximately nine months prior to the youth's admission. No current IEP was located among the documents provided by the MDJDC.

- Another youth [UX] was in custody from January 22 to February 26, 2007, or 26 school days. Her most recent case conference revising her IEP was held on March 23, 2005, and thus had expired well over a year prior to her admission to Marion. Again, no documentation was provided to indicate any action had been taken to update the youth's IEP.

- Another youth [CT] was in custody from January 28 to February 27, 2007, or 22 school days. The most recent case conference to update her IEP was held on January 17, 2006. This IEP expired just prior to the youth's admission to MDJDC, and yet no documentation was provided to indicate that any action had been taken to update the youth's IEP. All actions taken on behalf of a youth need to be clearly documented in the youth's file. Even when another school is responsible for the action itself, the school that is presently serving the youth should receive frequent progress reports to ensure the documents needed to certify eligibility and to direct service provision are in compliance with State and federal law.

School administrators also indicated that they were unable to provide speech, language, and other types of related services, and could not accommodate youth who required assistive devices or technology. Administrators stated that the facility did not have access to qualified consultants or assistive equipment. Services prescribed by a youth's IEP cannot be denied by the facility.

2. Access to Education

The IDEA requires that all youth with certain disabilities have access to free and appropriate public education (FAPE) which meets the standard of the State education agency. 20 U.S.C. §§ 1401(8)(b) [eff. July 1, 2005]; 20 U.S.C. §§ 1401(9)(b); 1412(a)(1)(A). See also 34 C.F.R. § 300.600(a)(2)(ii). However, Marion routinely fails to provide certain categories of youth with access to any educational services, including special education. Some youth in isolation are denied *any* educational services. Similarly, youth who are scheduled to be released to the Department of Corrections ("DOC") do not attend any school.

Finally, Marion does not provide any special education services to girls unless at least two girls are eligible for the services.

These practices can severely impact a youth's education. For example:

- We identified 25 youth (20% of the total youth population at Marion) who had been at the facility for more than three days and who were not enrolled in school.[19] Eleven of these 25 youth were eligible for special education services, but were not receiving them.

- Two youth, [OB] and [QN], had been at the facility for 19 days and 35 days, respectively, and were eligible for special education services under the Other Health Impaired category, but neither had been enrolled in school.

- Two youth with learning disabilities, [SC] and [IT], had been at the facility for 21 days and 29 days, respectively, but neither had been enrolled in school.

- One youth [KI] had resided at Marion for 105 days, yet had never been enrolled in school.

Marion's failure to provide access to any educational services for some youth, including special education, violates youths' rights to access to education. Even when youth have access to an educational program, the program is inadequate. Marion provides a total of 260 minutes of academic instruction daily, which is less that the 360 minutes of instruction required by state law. Ind. Code § 20-30-2-2. Marion attempts to rationalize this disparity by claiming that the entire school has been designated as an Alternative School, which requires fewer instructional hours. However, a blanket decision to enroll all youth in an Alternative Program fails to account for the individual needs of youth and appears to be a decision made purely for the convenience of the facility rather than on the needs of the youth. Indeed, some youth at MDJDC who have been on track for high school graduation could be derailed by a stay at MDJDC, as the facility cannot accommodate their course of study.

IV. REMEDIAL MEASURES

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

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[19] Three days is the generally accepted standard for the period of time in which youth must be enrolled in school following admission to a juvenile justice facility.

A. Protection from Youth Violence

1. Ensure that youth are adequately protected from physical violence committed by other youth.

2. Ensure that the facility maintains sufficient levels of adequately trained direct-care staff to supervise youth safely.

3. Ensure that staff receive adequate pre-service and in-service training in behavior management, de-escalation techniques, assault intervention, and suicide prevention.

4. Ensure that the facility provides adequate and appropriate structured youth programming.

5. Ensure that there is an adequate and effective behavior management system in place, and that the system is regularly reviewed and modified in accordance with evidence-based principles.

6. Ensure that the facility develops and implements an adequate objective housing classification system to ensure safe housing assignments.

B. Protection from Excessive and Unlawful Isolation

1. Ensure that youth at the facility are not isolated for excessive periods of time or in an arbitrary or disproportionate manner.

2. Ensure that youth sanctioned to punitive isolation receive adequate procedural safeguards.

3. Ensure that youth sanctioned to punitive isolation receive adequate programming and essential services.

C. Suicide Prevention Measures

1. Develop adequate suicide prevention policies and practices.

2. Perform required observation checks in random intervals. Record the checks and verify that the checks are occurring.

3. Provide cut down tools in all housing units.

D. Protection from General Harm

1. Ensure that the facility develops and maintains an adequate youth grievance system.

2. Ensure that all allegations of child abuse and mistreatment are referred to the appropriate external agency.

3. Ensure that the facility adequately and timely investigates serious incidents and allegations of staff misconduct.

E. Fire Safety

1. Conduct and document adequate fire drills.

2. Ensure that all employees have keys to the fire alarm boxes.

3. Ensure that fire hazards are eliminated.

F. General Sanitation

1. Ensure that youths' clothing is properly cleaned, dried, and transported.

2. Ensure that hygiene practices minimize the risk of disease transmission (e.g., that youth do not share deodorant).

3. Ensure that all mattresses, pillows and gym pads are adequately cleaned and disinfected.

4. Ensure regular and periodic cleaning of all housing areas, including toilets and showers. Ensure that regular and periodic insect control measures are performed.

G. General Safety

1. Develop and implement proper chemical safety measures.

2. Ensure that safety hazards are eliminated.

H. Special Education

1. Ensure timely and appropriate assessment and identification of youth qualified for special education services.

2. Provide qualified youth with adequate special education instruction, by an adequate number of special education teachers.

3. Develop, revise as appropriate, and implement adequate Individualized Education Plans and provide necessary related services.

4. Provide adequate access to educational services.

* * *

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

We hope to continue working with the County in an amicable and cooperative fashion to resolve our outstanding concerns regarding Marion. Assuming there is a spirit of cooperation from the County, we also would be willing to send our consultants' evaluations under separate cover. These reports are not public documents. Although the consultants' evaluations and work do not necessarily reflect the official conclusions of the Department of Justice, their observations, analysis, and recommendations provide further elaboration of the issues discussed in this letter and offer practical technical assistance in addressing them.

We are obligated to advise you that, in the entirely unexpected event that we are unable to reach a resolution regarding our concerns, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct deficiencies of the kind identified in this letter 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1). We note that we are also authorized, pursuant to 42 U.S.C. § 14141, to initiate a suit to address the above described conditions.

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

Sincerely,

/s/ Wan J. Kim
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