

August 4, 2005

The Honorable Linda Lingle  
Governor, State of Hawaii  
Executive Chambers  
State Capitol  
Honolulu, HI 96813

Re: Investigation of the Hawaii Youth Correctional  
Facility, Kailua, Hawaii

Dear Governor Lingle:

I am writing to report the findings of the Civil Rights Division's investigation of the conditions at the Hawaii Youth Correctional Facility ("HYCF") in Kailua, Hawaii. On August 16, 2004, we notified you of our intent to conduct an investigation of HYCF pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, and the pattern or practice provision of the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141 ("Section 14141"). CRIPA and Section 14141 give the Department of Justice authority to seek remedies for any pattern or practice of conduct that violates the constitutional or federal statutory rights of children in juvenile justice institutions.

From October 5, 2004 to October 8, 2004, we conducted an on-site inspection of HYCF aided by our expert consultant in the field of juvenile justice. We interviewed administrators, the acting correctional supervisor, youth corrections supervisors, youth correctional officers ("YCOs"), medical staff, mental health staff, educators, social workers and youth at HYCF. On October 26, 2004, we conducted individual interviews with each of the girls from HYCF temporarily placed at the Salt Lake Valley Detention Center ("SLVDC") in West Salt Lake City, Utah, regarding the conditions at HYCF. Before, during, and after our tour, we reviewed an extensive number of documents including, but not limited to, incident reports, juvenile correctional records,

youth grievances, discipline records, medical files, mental health progress notes, shift logs, staff training materials, and school records. Consistent with our commitment to provide technical assistance and conduct a transparent investigation, we provided two extensive de-briefings following our tour: one with Sharon Agnew, the Executive Director of the Office of Youth Services ("OYS"), and Kaleve Tofono-Iosefa, the Administrator of HYCF; and another with Attorney General Mark Bennett, then-First Deputy Attorney General Richard T. Bissen, Jr., and Ms. Agnew. During the de-briefings our consultant expressed his initial impressions and concerns, and attorneys for the Civil Rights Division also presented their discoveries regarding dangerous suicide risks at the facility. Shanetta Y. Cutlar, Chief of the Special Litigation Section, sent an October 15, 2004 letter to Mr. Bissen documenting suicide hazards at HYCF and requesting that the State of Hawaii ("State") take immediate remedial action.<sup>1</sup>

We commend the Administrator and her staff at HYCF, as well as Ms. Agnew and administrators at OYS, for their helpful and professional conduct throughout the course of our investigation. The State granted immediate and unfettered access to HYCF, permitted us to interview the staff and residents, and provided all documents we requested regarding the facility and the youth confined there. We also appreciate the State's receptiveness to our consultant's on-site recommendations. Indeed, we note that Hawaii has stated that it has implemented a number of the recommendations.

Consistent with the statutory requirements of CRIPA, we now write to inform you of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to address the deficiencies we have identified. As more fully described below, we conclude that certain deficiencies violate the constitutional and federal statutory rights of the youth confined at HYCF. In particular, we find that youth confined at HYCF suffer harm or risk of harm from constitutional deficiencies in the facility's confinement practices, suicide prevention procedures, and provision of access to mental health

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<sup>1</sup> Mr. Bissen responded to Ms. Cutlar's letter on November 23, 2004. In his letter, Mr. Bissen identified remedial measures the State had taken to address our concerns.

and medical care services. We also find that the State fails to provide access to required education services pursuant to the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. § 1401, and Section 504 of the Rehabilitation Act of 1974 ("Section 504"), 29 U.S.C. § 794.

### **I. BACKGROUND**

HYCF is the state's sole juvenile justice facility. HYCF, a 71-bed facility, is comprised of two separate facilities with three housing units: two boys' housing units and a girls' housing unit. With certain exceptions, HYCF houses boys confined for long terms at the main secure custody facility ("SCF") and places boys adjudicated for short terms at the Ho'okipa Makai ("Ho'okipa"), a cottage unit located approximately one-quarter mile from the main facility.<sup>2</sup> The SCF is comprised of a central courtyard surrounded by three housing modules, with ten cells and a common area in each module, a school, a gymnasium, kitchen facilities, offices for administrative and medical staff, and two isolation cells. Ho'okipa has two dormitories, with bunk-bed space for 12 boys in one room and six boys in the other, and three single isolation units.

The Observation and Assessment Cottage ("O&A"), a freestanding living unit located a few hundred feet from SCF, has ten cells that provide space for up to 20 female youth. O&A also has an attached school and a fenced-in area for outdoor recreation. The girls' facility was vacant at the time of our visit, as the State had transferred the girls to SLVDC for temporary placement.<sup>3</sup>

### **III. FINDINGS**

It is no exaggeration to describe HYCF as existing in a state of chaos. The most fundamental problem that plagues HYCF is the absence of policies or procedures to govern the facility.<sup>4</sup>

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<sup>2</sup> HYCF housed aggressive youth sentenced to short terms at SCF at the time of our visit.

<sup>3</sup> The girls returned to HYCF on or about November 18, 2004.

<sup>4</sup> Prior to our visit, the State provided us with a set of policies and procedures that purportedly governed operations at  
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The absence of rules or regulations has permitted a culture to develop where abuse of youth often goes unreported and uninvestigated.

Security staff have stepped into the vacuum of order and taken control of every aspect of the operation of the facility. Security staff, who have received no training in over five years and have no rules to guide their decisions, routinely use excessive force against youth, confine youth to their cells for days on end, discipline youth without justification or oversight, deny youth access to medical and mental health services, and prevent youth from receiving education. It appears that this situation is not of recent advent. Indeed, it is our impression that the situation has existed for years.

In the past few years the State has taken a number of measures to remedy the absence of accountability at HYCF. At the ground level, administrators have attempted to bring order to HYCF by issuing rules and policies in the form of memoranda. Their efforts have been countered at every juncture by security staff who routinely ignore administrative directives and suffer few, if any, repercussions. Indeed, as detailed below, YCOs continue to run the facility as they choose, regardless of the negative impact on the health and welfare of the youth confined there.

At a higher level, the State has expended considerable resources to reform HYCF. The State has taken the initiative to seek technical assistance from consultants and organizations. The work of these individuals and groups has been facilitated by

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HYCF. The Department of Public Safety, the department that governed the operations of HYCF until 1991, issued the policies in 1984. The Hawaiian legislature repealed them in 2002. Regardless of the legislative action, the policies were outdated and intended for an adult institution. Further, in the course of our interviews, we found that staff and administrators were either unaware of the existence of any policies or procedures or were cognizant of their existence yet ignorant of their content. To its credit, the State recently drafted new policies based on model guidelines issued by the American Correctional Association, but has yet to implement them at the facility. The State has stated that it has provided training to its staff on a few of the new policies, but not all.

the State's remarkable candor in recognizing its deficiencies. We applaud the State for accepting the advice and recommendations of these professionals and pursuing long term, holistic solutions rather than stop-gap measures. Nevertheless, the State's reform movement at HYCF is in its nascent stage and will take some time to produce results. In the interim, youth continue to suffer unduly harsh and punitive conditions on a daily basis.

#### **A. PROTECTION FROM HARM**

As a general matter, the State must provide confined juveniles with reasonably safe conditions of confinement. See Youngberg v. Romeo, 457 U.S. 307, 315-24 (1982); Bell v. Wolfish, 441 U.S. 520, 535-36 & n.16 (1979); Gary H. v. Hegstrom, 831 F.2d 1430, 1432-33 (9th Cir. 1987). As part of this constitutional mandate, confined juveniles must be protected from physical assault and the use of excessive force by staff. Youngberg, 457 U.S. at 315-16. See also Redman v. County of San Diego, 942 F.2d 1435, 1441 n.7 (9th Cir. 1991) (en banc) (finding that the State has an affirmative duty to protect juveniles confined in an adult detention center from harm at the hands of other detainees). Neither the Supreme Court nor the Ninth Circuit has ever determined definitively whether the Eighth Amendment or the Fourteenth Amendment provides the governing constitutional standard for conditions at facilities, like HYCF, where juveniles are incarcerated for both penal and rehabilitative purposes. See Stevens v. Harper, 213 F.R.D. 358, 373-374 (E.D. Cal. 2002); see also Haw. Rev. Stat. § 352-2.1 (noting that purposes of youth correctional facilities in Hawaii are to incarcerate, punish, and provide institutional care to juveniles so as to facilitate their eventual reintegration back into the community).<sup>5</sup> Because the conditions at HYCF are so egregious as to violate even the more stringent Eighth Amendment standard, it is not necessary to reach that issue for purposes of this letter.

Our investigation revealed major constitutional deficiencies in the harm protection measures in place at the facility. In particular, the State fails to protect youth from: (1) self harm; (2) staff violence; (3) youth-on-youth violence; (4)

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<sup>5</sup> Where the purpose of the juvenile facility is exclusively rehabilitation, the Ninth Circuit has held that the Fourteenth Amendment's more relaxed standard controls. See Gary H. v. Hegstrom, 831 F.2d 1430, 1432 (9<sup>th</sup> Cir. 1987).

excessive use of disciplinary isolation; (5) lack of supervision; and (6) an inadequate grievance system.

### **1. Self-Harm**

There appear to serious problems in the way the State attempts to protect youth at HYCF from self-harm. In particular, we observed that: (a) staff fail to assess suicidal youth adequately; (b) staff fail to supervise adequately youth on suicide precautions and in disciplinary isolation; (c) staff lack training to respond appropriately to suicide attempts; and (d) the State houses youth at risk of self-harm in unsafe circumstances. The overarching problem is a lack of policies and procedures to instruct staff. Without policies governing suicide prevention, supervision, and reporting -- and training in such policies -- the risk that a youth at HYCF will commit self-harm is quite high.

The risk of self-harm is not hypothetical. During our visit to HYCF we learned that two female youth made serious attempts to commit suicide on September 10, 2004, one month after we notified you of our investigation:

- A youth used her bra to hang herself from the bunkbed in her cell. Another youth found her hanging and yelled for the YCO on duty. The YCO arrived at the cell, became frightened, and dropped his keys. A second youth then grabbed the keys, unlocked the door, and lifted up the unconscious young woman. Another resident removed the bra strap from the young woman's neck and laid her on the floor.
- At the same time, in a different cell in the same unit, a second youth attempted suicide by hanging. She tied one end of a bed sheet around her neck and the other end to a pole. A YCO and another youth responded and removed the sheet from the suicidal youth's neck. The youth had attempted suicide earlier that day by cutting herself 21 times with a bra wire, and had further attempted suicide two days earlier by cutting her wrist with a razor.

Equally disturbing, we found that youth use staples, toothpicks, plastic cups, and pieces of broken tiles to cut into their flesh. During our interviews we observed carvings on their faces, arms, and legs. This behavior apparently occurs with the full awareness of the staff charged with keeping youth safe.

**a. Insufficient Assessment of Suicidal Youth**

It is both customary practice and legally essential for incarcerated juveniles who are identified as potentially suicidal to be placed on suicide precaution and monitored by mental health professionals. Unfortunately, a review of corrections and medical files at HYCF revealed that few measures are taken to ensure that staff properly learn of, or supervise, youth who self-identify as suicidal at intake. The failure to transmit this information creates an unnecessary risk that the individuals may harm themselves and, at the same time, prevents correctional officials from undertaking precautionary protective measures.

We set forth below several examples where staff failed to alert others that youth have a history and/or tendency to engage in self-harming behavior:

- When he arrived at HYCF on June 8, 2004, a youth stated to a social worker that he had attempted to commit suicide ten days prior while in detention. However, a review of the youth's intake evaluation and of his medical and correctional files revealed that the information was not communicated to either mental health professionals or security staff.
- In a youth's file, a suicide screening form dated September 20, 2004, and an intake evaluation dated September 24, 2004, both indicated that the youth was contemplating suicide. However, there is no evidence of suicide precautions in his medical record.
- A suicide screening form in one youth's file dated September 22, 2004, included notations that the youth previously attempted suicide by hanging, that there was a family history of suicide, and that the youth had received psychiatric interventions. Despite this clear evidence of a past history of self harm, the youth's intake evaluation, which was dated five days later, did not contain a history of suicide attempts or past psychiatric problems. No special precautions were either recommended or taken.

**b. Inadequate Supervision of Youth on Suicide Precautions**

In addition to appropriate monitoring by mental health professionals, potentially suicidal youth require appropriate

supervision by direct care staff, who are the only staff in the facilities on duty 24 hours a day. We found that supervision of suicidal youth by direct care staff throughout the facilities was inadequate.

It is essential that staff document their observations and denote the actual times of their checks on suicidal youth. Policies and procedures should dictate that these functions occur with regularity. Supervisory personnel, meanwhile, should be verifying that line staff are performing assigned duties. Yet neither of these things seem to be occurring at HYCF.

At the time of our tour, HYCF had no policies or procedures governing suicide observation.<sup>6</sup> We found that security staff unilaterally remove youth from suicide observation status without the approval of mental health professionals. For example, following a September 8, 2004 suicide attempt in which a youth slit her wrist with a razor, mental health professionals ordered that security staff place the youth in a secure cell with "one-on-one line of sight supervision" for at least four days. Instead, the youth was only monitored by camera during the night. The next morning, a YCO permitted the youth to spend extensive time – completely unobserved – performing chores in a cleaning closet containing hazardous chemicals. When a nurse questioned the YCO regarding this lapse in judgment, the YCO reportedly responded that she did not know the youth was on suicide watch and dismissed the nurse's concerns with the comment: "Okay. Go away." Amazingly, the youth continued to perform housekeeping tasks outside the sight of the YCO.<sup>7</sup> Shortly thereafter, the youth approached the nurse and produced several paper clips she found while cleaning, confessing that she had contemplated using the paper clips to harm herself. Two days later, the youth attempted suicide again by cutting her wrist and hanging.

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<sup>6</sup> The State issued a draft policy governing suicide prevention entitled "Suicide Prevention and Precaution." The draft policy addresses some, but not all, of our concerns. We have not formally commented on the policy because it is still under review by the State. Nonetheless, the drafting of a policy is an encouraging first step towards protecting youth from self-harm.

<sup>7</sup> The YCO assigned to observe the youth recorded in the shift log that the youth was "cleaning while being counseled." There was neither evidence nor reason to believe that the YCO provided any counseling.



We also found that security staff routinely fail to conduct observations of youth on suicide watch. For example, a May 15, 2004 report on one suicidal youth contains a notation that the corrections supervisor had instructed the YCOs on duty to monitor the youth *every 15 minutes* and record the time and observations of each check. Our review of the log, however, indicated that the YCOs performed the checks (or at least recorded their observations) only sporadically over the following 24-hour period. Occasionally, there were observations memorialized on 15-minute intervals, while at other times, checks appear to have occurred only on the half-hour or hour.

**c. Lack of Preparedness for Suicide Attempts and Other Self-Harm**

Staff training at HYCF in suicide prevention measures is likewise highly inadequate. There is universal agreement among experts that staff who interact with potentially suicidal youth must be trained to detect, assess, and if necessary, intervene to prevent a suicide. HYCF does not meet that standard.

**i. Lack of Training**

The State has failed to provide YCOs with training regarding suicide attempts nor has it instructed YCOs on strategies for de-escalating youth who are engaged in self-harming behaviors. As a result, security staff monitoring youth on suicide precautions have no guidance on how to respond to threats (or reported ruminations) of self-harm, how to deal with actual suicide attempts, or what measures to take to ensure that a youth who engages in self-harm receives prompt treatment from mental health professionals. A good example of the danger that inadequate staff training presents is an incident that occurred on December 23, 2003. Around midnight that evening, security staff found a youth hanging from a bed sheet tied to the vent in his cell. Yet the staff on duty failed to notify the medical or mental health units immediately. Instead, they waited *two-and-a-half hours* before transporting the youth to the emergency room. To make matters worse, when the juvenile returned from the hospital, staff made no effort to contact the facility's on-call nurse or any other mental health professional. Staff simply placed the youth in a restraint chair for four-and-a-half hours until the facility nurse arrived at work the next morning. This kind of delay is difficult to understand or excuse.

## ii. Lack of Equipment

Having emergency equipment readily available to staff, and ensuring that staff are trained in the use of that equipment can make the difference between life and death in the context of suicide prevention. To take one basic example, security staff should have access to a cutting tool at all times in order to respond to attempts to commit suicide by hanging. Such a state of preparedness, however, does not exist in our judgment at HYCF.

When our experts questioned HYCF personnel about proper suicide prevention procedures, the myriad of answers we received illustrated the inadequacy of the state of training. Consider the following:

- One YCO did not know if there was a written suicide policy, but stated that, were she to encounter a youth hanging himself/herself, she would cut the youth down. But she acknowledged that there are no cut-down tools at the facility nor we should even know where she might find a knife or scissors.<sup>8</sup> She then changed her mind and said she would call a "Code Red" and hold up the youth until others arrived.<sup>9</sup>
- Another YCO indicated that, in such a scenario, he would attempt to cut down the youth, but that he did not know where he would find scissors, a knife, or other cut-down tools.
- Yet another YCO said he would call "Code Red" and wait for other staff to arrive. The YCO added that he would proceed with caution in case the suicide attempt was a "set up" by the youth.

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<sup>8</sup> The nurses reported that they have ordered and received cut-down tools, which are stored in the infirmary. These tools are not accessible by security staff.

<sup>9</sup> A "Code Red" is called when emergent conditions exist. Staff leave their assigned posts and rush to the location of the crisis. This practice places youth in danger as HYCF suffers from chronic staff shortages and youth who are supposed to be in the care of Code Red responders are left unsupervised for great lengths of time.

#### **d. Unsafe Housing of Youth at Risk of Self-Harm**

It is also imperative that potentially suicidal youth be housed in living quarters that are suicide resistant. HYCF lacks such an infrastructure. At the time of our tour, the cells and housing modules presented structural hazards that posed substantial risks to suicidal youth. Set forth below is a list of the hazards identified during our visit:

- Each cell had two metal grilles that covered air vents. These grilles had perforations through which a youth could thread a piece of plastic or cloth to hang himself.<sup>10</sup>
- The sinks within the cells had bases that projected from the wall. A youth could fashion a noose to hang himself from that type of sink.
- Many of the cells had broken floor tiles. A youth could break off a portion of the tile and use the shard as a cutting tool to harm himself.
- The shower stall in the isolation area by the central control center had a shower head large enough for a youth to use it to affix a noose and hang himself.

Fortunately, our consultant advised that the State could fix many of the hazards quickly and at minimal cost. To its credit, the State has promptly responded to our consultant's remarks. In a November 23, 2004 letter, the State indicated that it had removed the metal grilles and installed new vents, started to retrofit sink bases with arc-welded stainless steel skirting, replaced shower heads, removed and replaced floor tiles, and installed 20 fiberglass beds in the girls' unit.<sup>11</sup>

## **2. Staff Abuse**

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<sup>10</sup> On December 23, 2003, security staff found a youth hanging from a rope braided from his mattress and threaded through the grille vent in his cell.

<sup>11</sup> At the time of our tour, the girls' unit was outfitted with bunk beds, from which one of the youth had attempted suicide by hanging.

Another concern revealed by our investigation was occasional physical abuse of youth by HYCF staff. Such abuse often occurs during "takedowns," when YCOs use physical management to control a youth. While force may be justified in certain circumstances, it appears that YCOs use the takedown as the first level of force. To be sure, there is no constitutional requirement that correctional facilities use the absolute minimal amount of force necessary to control a disruptive youth. But the practices at HYCF tend to exacerbate the already difficult task of rehabilitation. Moreover, the absence of any policies or procedures governing use of force, not to mention the lack of training in proper procedures and techniques, incubates an environment that is receptive to abuse.

**a. Lack of Training and Proper Technique**

During our tour of HYCF we asked YCOs about the proper methods for employing physical force. Few, if any, of the answers comported with methods condoned in either adult corrections or juvenile justice. Indeed, the answers provided by YCOs indicated that security staff may be employing tactics that pose a grave risk of injury or death. For example:

- One YCO reported that he lays on top of a youth and uses his considerable weight to smother and restrict the movement of the youth. The YCO stated that he would get up off the youth only when the youth stopped struggling. The use of such a method presents the real possibility of positional asphyxiation.
- Another YCO reported that she uses the "chicken wing" to restrain youth. The YCO explained that she comes up to the youth from behind and wraps her arms around the youth's arms at the elbows, then pulls the youth's arms together toward the center of his back.
- Yet another YCO stated, with respect to the use of force, "For juveniles, anything goes."

In the absence of policies governing uses of force and training, it appears that YCOs feel justified in using whatever force they deem appropriate, regardless of the threat posed. This trend has not gone unnoticed by other staff or administrators. In October 2003, a nurse sent a memorandum to the then-Acting Administrator and stated that takedowns at HYCF had become "more frequent," "appear to be escalating," and that

the amount of force "appears to be on the verge of excess." Meanwhile, the nurse continued, "injuries are becoming more severe . . . resulting in more Emergency Room visits." The physician providing services at the facility noted that he had informed facility and OYS administration via memorandum that the "[r]isk of being killed in a takedown is a real possibility" due to lack of training on the part of YCOs. Despite the concerns expressed by the medical staff, the State did not provide YCOs with any training in the use of force.

#### **b. Examples of Abuse**

Our investigation uncovered numerous disturbing uses of excessive and unnecessary force by YCOs. The following examples are illustrative:

- In September 2004, a YCO tackled a youth for refusing to enter his room. The YCO placed the youth in a choke hold with the youth's face pressed against the officer's stomach and the officer's feet wrapped around the youth. Another YCO gouged the youth's eyes with his fingers. The YCOs then placed the youth in handcuffs and hogtied him.
- In July 2004, a YCO choked a youth for ten seconds, applying enough pressure to leave red hand prints on the youth's neck.
- On June 11, 2004, a YCO physically assaulted a youth during an argument over whether the youth could have cereal for an evening snack. The YCO shoved the youth and punched him, first in the back of the head and then to the face and body. The YCO slapped the youth, choked him, and threw him against the wall. The youth did not fight back. When questioned during an internal investigation, the YCO conceded that he "just lost it."<sup>12</sup>

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<sup>12</sup> An internal investigation found substantial evidence that a supervisor attempted to stifle any investigation of the incident. The supervisor hid documents regarding the incident and attempted to bargain with the assaulted youth in order to obtain his silence. The investigation began only after a youth who had witnessed the assault encountered the Administrator at lunch and informed her of the incident.

- On February 1, 2004, a youth reported that during a takedown, a YCO held him from behind in a choke hold, punched him in the face, slammed him against the wall, and then punched him in the nose. The youth suffered numerous injuries including a nose bleed, an abrasion to the side of his head, and a reddened area around the side of his neck and throat.
- On January 21, 2004, a YCO grabbed, squeezed, and twisted the testicles of a youth for at least 15 seconds as the youth lined up to return to school. When the youth sought medical attention, the YCO encountered the youth outside the medical unit, laughed at him, and mockingly asked: "What, you want me to grab your balls again?" An internal investigation of the incident indicated that the YCO had grabbed the genitals of other youth on at least two separate occasions as well.<sup>13</sup>
- YCOs abused a youth on four separate occasions over an eight-week period in the Fall of 2003. On August 25, 2003, the youth complained to the HYCF nurse of headaches after a YCO punched him in the face during a takedown. Less than three weeks later, on September 12, seven to eight YCOs threw the youth to the floor multiple times and rubbed his face in the ground when he refused to go into his cell; the youth suffered bruises and abrasions on his face, back, chest, shoulder and knee. The following month, on October 8, the youth was the subject of an unprovoked attack by a YCO, who elbowed him in the head, arm, and chest. Finally, on October 22, the youth suffered head trauma after four or five YCOs restrained him; a facility nurse noted multiple facial, head, and neck abrasions, including the imprint of a watchband on his trachea and abrasions possibly resulting from a shirt twisted tightly around his neck.
- On June 31, 2003, a YCO separated two youth who were engaged in a fist fight. In the process, the YCO slapped and punched one of the youth. The YCO later entered the youth's cell and punched him in the face.

### **c. Failure to Investigate Abuse**

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<sup>13</sup> The State indicted the YCO for Sexual Assault in the Third Degree on September 15, 2004.

Equally disturbing, the State fails to properly investigate staff abuse of youth at HYCF. In 2004, the State completed only four internal investigations of reported abuse. As of December 31, 2004, at least 17 allegations of abuse from 2003, and two from 2004, are pending investigations. Our review also found many allegations of abuse that were not under investigation at all.

We reviewed medical reports, youth grievances, and incident reports from July 1, 2003 through August 31, 2004 for evidence of staff-on-youth violence.<sup>14</sup> We identified 37 incidents where facility documents identified physical contact between a staff member and youth that led to an injury suffered by the youth. Not a single one of the incidents had been investigated. For example, in February 2004, a youth filed a grievance stating that two YCOs slammed him against a metal door and punched him in the nose. Contemporaneous medical reports substantiated the youth's injuries and reiterated his claims of abuse. Yet there is no mention of the February 2004 incident in the list of pending investigations. Interestingly, as of July 2004, the list of pending investigations showed four other allegations of abuse against this particular juvenile, including allegations that YCOs "clotheslined" him, punched him, kicked him, and twisted his arm in 2003.

Those investigations that the State does complete are often deficient in any event. Of the two investigations we reviewed from 2004, for example, we found that youth made serious allegations of staff abuse that the facility apparently opted not to pursue.<sup>15</sup> In one, a youth informed an investigator that he had seen a YCO, who was not then under investigation, arrange for another youth to organize a "hit," or physical assault, on a fellow juvenile resident. Although the youth stated that the YCO

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<sup>14</sup> The haphazard practice of documenting incidents further hampers attempts to eliminate staff abuse. We found that staff routinely fail to document uses of force either in the logs kept on each unit or in specific forms completed when staff apply force.

<sup>15</sup> The State provided a list of HYCF's internal investigations. The State completed four investigations in 2004 -- two from 2003 incidents and two from 2004 incidents. In this section, we limit our discussion to the investigations of the two most recent incidents.

no longer worked at HYCF, it was impossible to verify this fact because the investigator never asked for the YCO's identity. Nor did the investigator refer the allegation to administrators for internal or criminal follow-up. Such a serious accusation warranted much more scrutiny than what was given.

### **3. Youth Assaults**

The law requires that juvenile justice institutions adequately protect youth from assault by other youth. Redman, 942 F.2d at 1441 n.7. The State often fails to live up to that obligation.

Part of the problem can be attributed to the absence of a classification criteria for housing youth. At present, security staff place youth committed for short periods of time at Ho'okipa and youth committed for longer terms at SCF. Within SCF and Ho'okipa, staff place aggressive youth with vulnerable youth regardless of the risk of harm.

The lack of supervision of youth is another contributing factor. The State has employed an insufficient number of staff at HYCF to monitor youth, and the staff that are employed there have no training in adequate monitoring procedures. As a result, youth are frequently able to exploit the gaps in supervision and harm other juveniles.

The following examples are emblematic of the widespread problem of youth-on-youth violence at HYCF:

- On October 6, 2004, a youth sexually assaulted another youth who was sleeping at the time. The victim and the perpetrator lived in a communal dormitory at the Ho'okipa Cottage. According to the statements of witnesses, the YCOs assigned to the cottage were in the kitchen and were not observing the youth in the dormitories.<sup>16</sup> As the youth slept, the perpetrator placed his penis on the mouth of the victim. The victim and another youth present in the dormitory at the time of the assault both indicated that this was not the first time the alleged perpetrator had acted out against the victim.

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<sup>16</sup> It was reported that three YCOs were on duty at the time.



- On or around August 24, 2004, several youth "mobbed," or jointly assaulted, another youth. There is no documentation indicating that the youth received medical attention. Further, security staff did not write injury or incident reports describing the attack. However, approximately two weeks later, the facility doctor noted that the youth had coughed up blood and complained that his right side hurt. Four weeks after the incident, the doctor noted that the youth still suffered from "iliac chest pain secondary to being kicked" four or five weeks prior.
- On July 14, 2004, a fight broke out between two youth in the day room of a housing unit. One youth struck another youth in the mouth with a pool stick. The victim grabbed the pool stick and struck the offender's hands.
- On May 24, 2004, a youth came up behind another youth sitting in a chair and struck him in the head with a dust pan. The victim bled profusely from a laceration starting at the top of his head and extending down to the forehead. It took ten stitches to close the wound.
- On April 20, 2004, a youth hit another youth in the face, giving him two black eyes. The victim's right eye was swollen almost completely shut. The YCO on duty waited two days to inform the medical unit of the youth's injury.
- On February 17, 2004, a youth repeatedly punched another youth in the head and face, giving him two black eyes. The YCOs on duty did not report the injury at the time of the assault.
- On November 3, 2003, three separate youth-on-youth assaults occurred in rapid succession. First, a youth hit another youth with a closed fist. While two YCOs took down the initial aggressor, a second youth assaulted another youth with a closed fist. A YCO tackled the second aggressor at the same time another YCO placed the juvenile in a restraining hold. AS YCOs attempted to put all the youth back in their modules, a third youth punched another juvenile in the jaw.

#### **4. Disciplinary Isolation**

Staff at HYCF isolate youth in their cells as part of "lock down" procedures for significant periods of time. We do not

suggest that these lock downs are facially unconstitutional or even unwarranted in all circumstances. See Sandin v. Conner, 515 U.S. 472, 485-86 (1995). But HYCF appears to ignore completely the adverse psychological side effects of prolonged isolation and, more importantly, seems to have adopted no standards governing when such confinement procedures may be validly employed.

Staff often confine juveniles to their cells simply because an insufficient number of YCOs have reported to work or because it is considered convenient for staff. A review of shift logs indicated that youth at HYCF routinely endure lock down for days on end. This practice has fomented tension amongst the juveniles and led to an increase in violence. It also has precipitated greater amounts of self-injurious behavior. HYCF residents consistently told us that they grow so frustrated or bored from the excessive use of lock down, that they choose to strike walls or doors with their fists rather than hit other youth or a YCO.

On a related note, during the course of our tour, we noted that many youth had carved and cut into their skin. Indeed, we noted that youth had visible cuts on their arms, legs, and faces. In explaining this physical desecration, the juveniles stated that, out of sheer boredom while confined to disciplinary isolation, they use plastic shards, paper clips, and the like to carve their flesh. We were particularly disturbed by the level and prevalence of cutting by female youth. All but one girl readily admitted that she cut herself. It appears that staff at HYCF have done little, if anything, to prevent youth from disfiguring themselves in this manner.

We also have serious misgivings about, and are concerned over the possible unconstitutionality of, the lack procedural protections afforded to youth who are placed in disciplinary isolation. Assuming a liberty interest can be established against HYCF's often long-term and baseless placement of juveniles into isolation, procedural due process interests would be implicated. See Wilkinson v. Austin, 125 S. Ct. 2384, 2395 (2005). Hawaii, however, offers not even minimal procedural protections to youth who are placed in disciplinary isolation. Indeed, YCOs unilaterally mete out discipline, frequently without any knowledge or oversight from supervisors or administrators. As far as we can tell, there are no controlling policies or procedures as to when lock downs may be validly employed.

## **5. Lack of Supervision**

### **a. Staff Shortages**

HYCF suffers from chronic staff shortages. Administrators informed us that the exigencies of staff shortages have created a situation where YCOs unilaterally choose when to report for work. Few, if any, scheduled staff report for duty on weekends. The former Acting Administrator informed us that, on Saturdays, it was a regular occurrence that only two YCOs were on duty to monitor three modules at SCF.<sup>17</sup> Staffing shortages became so severe at one point that administrators were forced to use non-YCOs, such as social workers, food service workers, and maintenance employees, to supervise housing units. The lack of staff poses a severe threat to the safety of youth.

Administrators stated that they often "hold over" staff, requiring YCOs to remain at their posts, if possible, beyond their tour of duty. YCOs informed us that they frequently are called on to work two consecutive shifts (despite not being scheduled to do so), and that it was not uncommon to work three or four shifts in a row. As a consequence, YCOs are exhausted, tend to sleep while on duty, and consequently fail to supervise youth adequately.

### **b. Exploitation of Youth**

We received multiple credible complaints that YCOs exploited youth. For example, in June 2004, the Youth Facility Administrator issued a memorandum stating that she had received "numerous complaints from (youth) and their families concerning (youth) being coerced to give food and personal items to staff" in exchange for "special favors" and "preferential treatment." Staff, she continued, also had been granting "extra privileges to youth by providing them with cigarettes for smoking in cells" and permitting them to stay up later than other youth. Incredibly, she added that some families complained of getting requests from juvenile residents to bring extra food and treats for YCOs during visits. The Youth Facility Administrator ordered staff to cease the practices immediately.

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<sup>17</sup> In response to our initial document request, HYCF provided us with a staff roster listing 51 youth corrections staff including 40 YCOs and 11 youth corrections supervisors.

## 6. Inadequate Grievance System

Although prisoners do not have a "claim of entitlement to a grievance procedure," Mann v. Adams, 855 F.2d 639, 640 (9th Cir. 1988), "[t]he right of meaningful access to the courts extends to established prison grievance procedures," Bradley v. Hall, 64 F.3d 1276, 1279 (9th Cir. 1995) (holding that a prisoner's First Amendment right to petition the government for redress of grievances encompasses the filing of inmate administrative appeals). HYCF's grievance system is dysfunctional.

The most significant legal deficiencies with the grievance system at HYCF are the difficulty in filing claims and the common presence of intimidation and retaliation against those youth who are able and dare to do so. The difficulty in submitting grievances is a problem whose source is easy to identify. Prior to August 2004, youth could only obtain grievances from YCOs or medical staff.<sup>18</sup> And in effect, YCOs were the sole source of grievance forms given that youth were frequently under lock down and needed the supervising YCO's consent for travel to the medical unit.<sup>19</sup>

But even if forms were readily available, many youth would be reluctant to use the grievance process because, based on the documents we read and interviews we conducted, the subjects of the complaints - typically, the supervising YCOs - often retaliate against the complainants. See Bradley, 64 F.3d at 1279 (right of access to facility's grievance procedure is violated when staff retaliate against inmate for having filed grievance).

More disturbingly, administrators repeatedly told us that staff at HYCF actively work to hinder investigations. The former Acting Administrator informed us that attempts to investigate alleged acts of abuse by staff were met with intransigence and deliberate interference from staff. When conducting an investigation, the former Acting Administrator stated that he

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<sup>18</sup> Per memorandum dated August 4, 2004, the Administrator instituted a new grievance policy mandating that all staff, including education and mental health staff, provide youth with grievance forms. Unfortunately, during our October 2004 tour, we found that staff did not consistently follow this directive.

<sup>19</sup> Medical staff stated that they advise youth to schedule a medical appointment in order to file a grievance.

would only talk to youth and YCOs "with [a] conscience." When asked to clarify, he observed that "if you talked to the wrong [YCO], you paid the price in staff shortages." YCO "sick-outs" reportedly paralyzed the institution and occurred on a routine basis when investigations were pursued. Incredibly, the former Acting Administrator stated that the target of, and witnesses to, an investigation often fail to report for duty for weeks on end in order to stifle the investigation. Nor are unscheduled absences to hinder investigations limited to the target or his/her associates; a supervisor tasked with conducting one particular investigation ceased appearing for work altogether and the investigation ultimately ground to a halt. The former administrator with whom we spoke conceded that he simply could not complete investigations because the institution was unable to endure the inevitably corresponding absences by YCOs.<sup>20</sup>

#### **B. INADEQUATE ACCESS TO MENTAL HEALTH AND MEDICAL CARE**

Like any individual incarcerated in a state correctional facility, juveniles are entitled to have access to adequate medical and mental health care. Our investigation strongly suggested that youth at HYCF have inadequate access to such care. HYCF contracts with outside providers for medical and mental health services. But a lack of communication between HYCF staff and the outside providers, as well as communication breakdowns between the different outside providers themselves, impedes the delivery of proper care. In addition, security staff frequently use the control they have over the movement of juveniles at the facility to restrict or deny altogether the provision of adequate medical and mental health care.

Poor communication between professional staff, including the mental health staff, medical staff, and social workers, is a barrier to proper care at HYCF. Virtually none of the professionals communicate in a systemically effective manner with their colleagues. For example, the providers of psychiatric care prepare weekly mental health reports for each youth and give those reports to the administrators. But the reports are not shared with either the social workers or the counselors.

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<sup>20</sup> The disappearance of evidence also hampered internal investigations. The former Acting Administrator reported that he attempted to locate a video tape from surveillance cameras that recorded a use of force by a YCO. The tape on which that incident was recorded was missing and never found.

Similarly, reports prepared by the social workers and counselors are not transmitted to the psychiatric care providers. As a result, mental health workers make decisions about medication and counseling without full knowledge of the needs of youth.

The complete control of YCOs over communication between the facility's youth residents and its professional staff is another, even greater, impediment to the delivery of adequate care. We acknowledge, of course, that security needs dictate a certain degree of restrictions on communications. The problem is that security staff have received no training whatsoever in the detection of mental health or medical problems, nor are there any policies guiding YCOs in dealing with youth with such issues. In essence, staff operates in a vacuum. Perhaps not surprisingly in such an environment, we found that YCOs routinely fail to alert mental health staff or on-site medical professionals when youth are in emergent need of care.

We were also concerned by the YCOs' apparent failure to ensure that youth who either commit acts of self-harm or are involved in physical altercations receive timely medical care. We compared incident reports with medical records and found that there were many instances where security staff stated that youth received care, yet there were no medical reports to substantiate the claim. The following examples are illustrative:

- On July 1, 2004, two youth engaged in a fist fight. A contemporaneous memorandum written by a YCO indicated that one of the youth requested and received a visit from the nurse. The documents provided by the State did not include a medical report from this incident.
- On April 20, 2004, one youth struck another youth in the face. The YCO waited approximately two days to notify the medical unit, at which time the YCO stated that a youth had a black eye but that he did not know how it happened. Medical staff made three requests to see the youth but were told that there were no YCOs to escort the youth to the medical unit. Medical staff finally conducted an exam in the youth's cell.
- On April 14, 2004, one youth slapped and punched another youth repeatedly. The assailant claimed that she had assaulted her victim at the victim's request. An internal memorandum from a supervisor documenting the incident does not indicate whether any medical attention was sought for

the youth. Nor do any of the other medical or mental health reports provided by the State indicate whether the victim received treatment.

- On January 15, 2004, a youth struck another youth with a closed fist to the youth's head, and two YCOs restrained the aggressor. A contemporaneous memorandum written by a YCO indicated that one of the juveniles received medical attention. The documents provided by the State did not include a medical report from this incident.
- On January 13, 2004, two juveniles were engaged in a fist fight. A contemporaneous memorandum written by a YCO indicated that one of the youth received medical attention. The documents provided by the State did not include a medical report from this incident.
- On December 19, 2003, two youth fought during breakfast. A YCO used physical force to place a youth in his cell. The youth reportedly had a bloody mouth after the incident. No medical reports document either incident. Documents provided by the State did not include medical or mental health reports indicating that the victim received treatment.
- On October 10, 2003, two youth punched each other, causing one to be taken to the medical center. The documents provided by the State, however, did not include a medical report from the incident.
- On September 8, 2003, a youth assaulted another youth in the day room of one of the modules. The victim curled up on the floor and received several blows to the head. A YCO shoved the perpetrator and held him against the wall. Although a contemporaneous memorandum written by the YCO indicated that a "nurse looked at" one youth and "everything seemed okay," the documents provided by the State did not include a medical report from the incident.
- On August 25, 2003, a YCO allegedly slammed the cell door on a youth's hand, breaking one of the fingers. The youth spoke with a social worker and requested that the social worker contact his mother so she could file a formal complaint. The youth declined to file a grievance stating that he feared retaliation by the YCO. The documents

provided by the State did not include a medical report from this incident.<sup>21</sup>

- On August 25, 2003, two juveniles were injured in a fight. There are no medical records of the injuries sustained by either youth. Additionally, one of the juveniles claimed that, in breaking up the fight, a YCO purposely punched him in the face and that the blow was not part of the take down. The youth stated that there was a small area of swelling on his forehead and that he experienced headaches following the incident. The documents provided by the State did not include a medical report from this incident.
- On August 20, 2003, at 6:00 p.m. a youth was hit in the eye while playing basketball. The nurse was not notified until the next morning at 11:00 a.m. and reported that the youth's right eye was swollen and discolored.

### **C. INADEQUATE ACCESS TO EDUCATION INSTRUCTION FOR YOUTH WITH DISABILITIES**

The Olomana School at HYCF provides instruction to all youth at HYCF, with the exception of those youth who have received a high school diploma.<sup>22</sup> HYCF has adequate educational resources. We found the educators to be dedicated and enthusiastic about their mission to educate some of Hawaii's most challenging youth.

Unfortunately, despite the richness of educational resources, and the desire of educators to teach juveniles confined at the facility, we found that the HYCF violates the statutory rights of youth with disabilities by failing to provide them with access to special education instruction and resources. The fault lies not with the educators. The problem, instead, is that security staff routinely cancel school and prevent youth with disabilities from receiving the services to which they are entitled.

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<sup>21</sup> The social worker's failure to take the initiative to notify her supervisors of the youth's allegation is another example where staff have been aware of abuse yet not reported it for further investigation.

<sup>22</sup> Educators at the Olomana School are employees of the Hawaii Department of Education.



## 1. Educational Requirements

In states that accept federal funds for the education of children with disabilities, as does Hawaii, the requirements of the IDEA apply to juvenile facilities. See 20 U.S.C. § 1412(a)(1)(A); 34 C.F.R. § 300.2(b)(1)(iv). Further, the requirements of Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, also apply to HYCF.<sup>23</sup> Bonner v. Lewis, 857 F.2d 559, 562 (9th Cir. 1988) (Section 504 applies to the provision of qualified sign language interpreters for deaf inmates in state correctional programs which receive federal financial assistance). The law forbids states from denying youth with a disability access to educational programs funded in part by the federal government.

Pursuant to the IDEA and Section 504, the State must ensure that youth who are entitled to receive special education services have access to such services. As of November 7, 2004, educators had identified approximately 63% of HYCF youth as having a learning disability and entitled to services under the IDEA.<sup>24</sup> Educators also had identified an additional 14% of youth at HYCF as having a disability and entitled to services under Section 504.<sup>25</sup> Added together, over 77% of the youth at HYCF were entitled to services under either the IDEA or Section 504. We found that these youth did not consistently receive those services in violation of federal law.

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<sup>23</sup> Section 504 of the Rehabilitation Act of 1973 prohibits States from excluding persons with a disability from participating in or benefitting from any State program or activity receiving federal financial assistance. The protections of this law, which apply to State prisons are extended to any person who: (i) has a physical or mental impairment that substantially limits one or more of such person's major life activities, (ii) has a record of such impairment, or (iii) is regarded as having such an impairment.

<sup>24</sup> Behavioral counselors at HYCF estimated that the number of youth at HYCF entitled to receive special educational services has ranged from 50% to 90% over the past two years.

<sup>25</sup> The youth identified as entitled to services under Section 504 did not qualify for services under the IDEA.

## **2. Lack of Access to Educational Services**

Special education laws under Title I of the IDEA require the State to provide each youth with a free and appropriate public education. 20 U.S.C. § 1412(a)(1)(A). In order to fulfill this obligation, the State must provide youth with an education that meets the standards of the State's educational agency. See 20 U.S.C. § 1401(a)(A)(11)(A)(ii)(II); 34 C.F.R. § 300.300; Haw. Rev. Stat. § 302A-436; Haw. Code. Reg. § 8-56-3. The education provided to juveniles at HYCF often does not meet these standards because of the constant denial of access to education instruction by security staff.

In discussions with educational staff, we learned that as of October 5, 2004, none of the youth had attended a full day of school since June 2004. During that time period, youth did not attend school for days on end. Security staff made the choice whether or not youth would attend school. The Olomana School educational staff stated that each day when they show up for work, security staff inform them if classes will be held that day. While it is difficult (and generally not our role) to second-guess security decisions, the frequency of school cancellations at HYCF is quite troubling.

### **III. REMEDIAL MEASURES**

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

#### **A. PROTECTION FROM HARM**

1. Train existing staff so that they perform their duties adequately and ensure that all staff demonstrate an understanding of and demonstrate the application of applicable skills. Ensure that there are sufficient, adequately trained staff to safely supervise youth.
2. Develop and implement adequate policies and procedures to ensure that youth who are at risk of suicide and youth who are at risk of engaging in self-injurious behavior are properly identified, supervised, and treated.

3. Provide staff with adequate training and equipment to identify and supervise youth at risk for suicide, and to intervene effectively in the event of a suicide attempt. Provide staff with training on the facility's suicide prevention policy, including the different levels of observation and the types of precautions that should be taken.
4. Remedy all suicide hazards in areas where youth with suicidal ideations may be potentially housed.
5. Develop and implement adequate policies and procedures to ensure that youth are adequately protected from physical violence committed by staff and other youth.
6. Develop and implement adequate policies and procedures regarding the proper use of force by YCOs and staff.
7. Develop and implement adequate policies and procedures to ensure that staff are adequately trained in safe restraint practices, that only safe methods of restraint are used, and that restraints are used only in appropriate circumstances.
8. Develop and implement adequate policies and procedures to ensure that staff adequately and promptly document and report all uses of force, incidents of violence, injuries and misconduct.
9. Develop and implement adequate policies and procedures to ensure that all incidents of violence, use of force, or serious injury are adequately investigated and that appropriate personnel actions and appropriate systemic remedies are taken in response to substantiated findings.
10. Develop and implement adequate policies and procedures to ensure an adequate classification system to house youth appropriately and safely.

11. Develop and implement adequate policies and procedures to ensure that staff do not exploit youth.
12. Develop and implement adequate policies and procedures to ensure that youth have access to a functional and responsive grievance process.
13. Develop and implement policies and procedures to ensure that staff do not intimidate or retaliate against youth who file grievances.

**B. ACCESS TO MENTAL HEALTH AND MEDICAL CARE**

1. Provide youth with adequate access to mental health care and ensure that appropriate interdisciplinary communication to facilitate mental health treatment occurs.
2. Provide youth with adequate access to medical treatment.

**C. ACCESS TO EDUCATION INSTRUCTION FOR YOUTH WITH DISABILITIES**

1. Provide youth with learning disabilities adequate special education instruction.
2. Develop and implement adequate individualized education programs, including vocational education, for youth with learning disabilities.
3. Develop and implement appropriate Section 504 plans for all eligible youth.

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During the exit interview at our on-site tour, we provided State officials with preliminary observations made by our expert consultant. State officials and facility staff reacted positively and constructively to the observations and recommendations for improvements. The collaborative approach the parties have taken thus far has been productive. We hope to be able to continue working with the State in an amicable and cooperative fashion to resolve deficiencies previously noted. Provided that our cooperative relationship continues, we will

forward our expert consultant's report under separate cover. Although the report is his work - and does not necessarily reflect the official conclusions of the Department of Justice - the observations, analyses, and recommendations provide further elaboration of the issues discussed in this letter and offer practical assistance in addressing them.

We are obligated to advise you that, in the unexpected event we are unable to reach a resolution regarding our concerns within 49 days after your receipt of this letter, the Attorney General is authorized to institute a lawsuit pursuant to CRIPA to correct the noted deficiencies. See 42 U.S.C. § 1997b(a)(1). We would very much prefer, however, to resolve this matter by working cooperatively with you. And we have every confidence that we will be able to do so. The lawyers assigned to this matter will be contacting your attorneys to discuss this matter in further detail. If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

/s/ Bradley J. Schlozman

Bradley J. Schlozman  
Acting Assistant Attorney General

cc: The Honorable Mark J. Bennett  
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Executive Director  
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Kaleve Tufono-Iosefa  
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Patricia Hamamoto  
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Hawaii Department of Education

The Honorable Edward H. Kubo, Jr.  
United States Attorney  
District of Hawaii

The Honorable Margaret Spellings  
Secretary  
United States Department of Education

The Honorable John H. Hager  
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