U.S. Department of Justice

Civil Rights Division

Special Litigation Section
P.O. Box 66400
Washington, DC 20035-6400

December 21, 1994

CRIPA Investigation, Wayne County (MI)

JI-MI-0001-0002

Mr. Edward H. McNamara
Wayne County Executive
600 Randolph St.
Detroit, MI 48226

Dear Mr. McNamara:

Re: Notice of Findings of Investigation,
Wayne County Juvenile Detention Facility

On March 21, 1994, we notified you of our intent to investigate the Wayne County Juvenile Detention Facility (hereinafter "WCJDF") (formerly known as "Wayne County Youth Home") pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. §1997 et seq. Consistent with statutory requirements, we are now writing to advise you of the findings of our investigation. Throughout the course of our investigation, Wayne County officials, WCJDF personnel, and counsel for Wayne County provided us with substantial assistance and their full cooperation. Our consultants expressed appreciation for this assistance, and we wish to join them in thanking you for your cooperation. In addition, we appreciate efforts which you have made to correct certain deficiencies.

In assessing the constitutionality of conditions at the WCJDF, the appropriate legal standard is whether conditions of confinement are reasonably related to the legitimate government objectives of rehabilitation, safety, internal order and security. Conditions which are unrelated to these objectives constitute punishment without due process of law and as such may not be inflicted upon juveniles. Cf. Bell v. Wolfish, 441 U.S. 520 (1979). See also Santana v. Collazo, 714 F.2d 1172, 1179-81 (1st Cir. 1983), cert. denied, 466 U.S. 974 (1984); Santana v. Collazo, 793 F.2d 41 (1st Cir. 1986); Nelson v. Heyne, 491 F.2d 352, 358-60 (7th Cir.), cert denied, 417 U.S. 976 (1974) (children in custody of the state have a constitutional right to treatment; Pena v. New York State Division for Youth, 419 F. Supp. 203, 207 ("[T]he detention of a youth under a juvenile justice system *absent provision for the rehabilitative treatment of such youth* is a violation of due process rights guaranteed under the Fourteenth Amendment.") (emphasis in original).

Conditions of confinement for youth in custody -- who have not been convicted of a crime -- are governed by the Due Process Clause of the Fourteenth Amendment, and not the less protective Eighth Amendment. Santana v. Collazo, 714 F.2d 1172, 1179 (1st Cir. 1983), cert. denied, 466 U.S. 974 (1984); see also Gary H. v. Hegstrom, 831 F.2d 1430, 1432 (9th Cir. 1987); H.C. by Hewett v. Jarrard, 786 F.2d 1080, 1084-85 (11th Cir. 1986); Milonas v. Williams, 691 F.2d 931, 942 & n.10 (10th Cir. 1982), cert. denied, 460 U.S. 1069 (1983). [1]/ Juveniles in custody have a constitutional right to adequate basic care, medical care, and protection from harm. Youngberg v. Romeo, 457 U.S. 307 (1982).

Because incarcerated juveniles do not lose their rights to equal protection under the law guaranteed by the Fourteenth Amendment simply by virtue of their incarceration, any disparity in treatment with non-incarcerated juveniles, such as provision of educational services, must be rationally related to a legitimate penological interest. Donnell C. v. Illinois State Board of Education, 829 F. Supp. 1016 (N.D. Ill. 1993). Additionally, any failure by the County to enforce the state's compulsory education law violates the procedural component of the Due Process Clause. See Gross v. Lopez, 419 U.S. 565 (1974). The Michigan School Code of 1976 mandates that any person in control of a child must send that child to the public school during the entire school year. M.C.L. § 380.1561(1).

Furthermore, juveniles at the WCJDF have federal statutory rights. The Individuals with Disabilities Education Act ("IDEA") (formerly, the Education of the Handicapped Act), 20 U.S.C. § 1400 et seq., was enacted to ensure that children with disabilities receive a free appropriate public education which "consists of educational instruction specially designed to meet the unique needs of the handicapped child, supported by such services as are necessary to permit the child 'to benefit' from the instruction." Board of Education v. Rowley, 458 U.S. 176, 188-89 (1982). The IDEA applies to the provision of educational services to juveniles in corrections facilities. Donnell C. v.

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[1]/ Even under the more restrictive Eighth Amendment, the constitutionality of conditions of confinement are not assessed on an item by item basis; rather, courts assess the totality of circumstances present at an institution to determine whether those conditions as a whole violate the constitution. See Tillery v. Owens, 907 F.2d 418, 426-27 (3d Cir. 1990) ("in determining whether conditions of confinement violate the Eighth Amendment we must look at the totality of conditions within the institution .... factors to be considered includ[e] food, medical care, sanitation ... ventilation, bedding, furniture, education and rehabilitation programs, safety and security and staffing."); Young v. Quinlan, 960 F.2d 351, 359, n.20 (3d Cir. 1992) (same).

Illinois State Board of Education, 829 F. Supp. 1016 (N.D. Ill. 1993); Green v. Johnson, 513 F. Supp. 965 (D. Mass. 1981).

Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794, prohibits discrimination on the basis of handicap by any recipient of federal financial assistance. Section 504 applies to the provision of educational services to juveniles in correctional facilities. Donnell C. v. Illinois State Board of Education, 829 F. Supp. 1016 (N.D. Ill. 1993).

Based on our investigation, we believe that numerous conditions at the WCJDF violate the constitutional and federal statutory rights of the juveniles detained therein. These conditions are set forth below:

I. WCJDF Has Severe Operational, Management, Staffing, and Programming Deficiencies.

1. **Failure to properly discipline employees found to have abused juveniles and failure to adequately investigate allegations of abuse.** WCJDF fails to protect its residents from physical abuse and other inappropriate behavior by staff. [2]/ During the past few years there have been ongoing incidents of physical abuse of WCJDF juveniles by staff members. Some staff who have documented instances of abuse -- some for serious and repeated offenses -- have been terminated, reinstated, and continue to work with youth at WCJDF as direct care workers or supervisors.

Several examples illustrate the severity of the problem at WCJDF. First, one direct care worker who was found guilty of hitting a child in the head with a chair and on another occasion stripped and paraded a youth naked in clear view of his peers was terminated and subsequently reinstated to his position at the facility. Second, a direct care worker who is now a supervisor has an over ten year work history characterized by repetitive abusive behavior as well as a series of terminations, reinstatements and suspensions. This individual was retained despite the fact that a former supervisor made a finding that this individual lacked the capacity and control to work in a child caring institution. Third, a current employee was found to have physically abused a juvenile and to have forced the youth to urinate on himself.

The facility's management has failed to conduct adequate competency reviews of its employees to ensure that they are able to function appropriately as direct care workers. WCJDF does not

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[2]/ During our tour, we observed one male staff member on the girls unit wearing a shirt featuring a scantily clad woman surrounded by daggers.

train any of its direct care staff regarding child abuse. Youth care workers are not uniformly trained and supervised in a recognized physical behavior management system or technique. The present staff investigator is a supervisor at the facility. In these circumstances the investigator cannot exhibit the degree of independence necessary to adequately review and investigate alleged incidents of mistreatment of juveniles at the facility. In sum, the failure of the facility to protect its charges from physical abuse threatens juveniles' health and safety and could result in serious injury.

2. **Overuse and misuse of force, discipline, and isolation.** Many of the staff at WCJDF do not practice safe physical restraint techniques. In one of the three applications of restraints observed during our on-site tour, a youth was rushed, taken down, and then carried by four staff members with his head bobbing dangerously close to the floor. In addition, many youth alleged that staff are unduly aggressive, "throwing" them into rooms, "banging" them into walls, and otherwise physically misusing force on them. A review of the abuse investigation reports confirmed that staff at times use inappropriate physical force on youth.

Our consultant determined that discipline and room isolation policies and practice at WCJDF are inappropriate and detrimental to the juveniles in the facility. The staff and the facility's procedures fail to clearly distinguish between temporarily placing a youth in his room for a "cooling off" period until he or she regains control and using room isolation as a sanction for misconduct. When juveniles are placed in isolation because they are out of control, the facility fails to provide continuous supervision, to provide counseling on an ongoing basis, or to provide juveniles with a mental health professional if they do not regain control after a short period of time. Additionally, the staff fails to conduct regular visual checks on juveniles who are in isolation for disciplinary reasons.

The staff at WCJDF rely too heavily upon room isolation to sanction both minor and major disciplinary infractions. There is also almost a complete lack of due process before a juvenile is placed in isolation. Youths experience isolation for excessive periods of time (up to three days) for a wide variety of offenses. Dates and time periods of isolation are not consistently logged and staff have too much latitude in placing juveniles in isolation. For example, youths are placed in isolation for suicide attempts, failure to follow directions, verbal assaults, excessive profanity, horseplay and fighting.

Youths at the facility typically spend one to three days in isolation, almost always without educational programs and without exercise periods. Additionally, youths are not provided with any furniture in the isolation room to sit on except a metal bed

frame. This excessive and inappropriate use of room isolation builds up resentment within youth, adds to youth's feelings of depression and alienation, disrupts their school placement, and makes it difficult for staff to impose effective sanctions for truly serious misconduct.

Juveniles at the facility are also forced to "stand track" -- i.e., standing facing their doors, sitting, or standing looking down the hallway in public view. Sometimes juveniles are forced to "stand track" for excessive periods of time and for minor infractions. This method of discipline humiliates, demeans juveniles in front of their peers, and is inappropriate.

The WCJDF has an inadequate grievance policy. Many juveniles complained about the futility of asking staff for grievance forms. In addition to a formal grievance process, the facility needs to make a concerted effort to listen and respond to juveniles' legitimate complaints.

3. **Inadequate staffing.** WCJDF is severely understaffed. It is not unusual for one staff to supervise 18-20 youth. Additionally, there are only two counselors for the entire facility. The two counselors are completely overwhelmed by the scope of their responsibilities. Such staffing is completely inadequate to properly supervise and care for the juveniles housed in this facility. The facility unduly relies on overtime to cover the direct care shifts.

4. **Inadequate supervision.** WCJDF fails to adequately supervise the juveniles in its care. For example, the staff fails to consistently monitor juveniles who are held in holding rooms for up to several hours prior to their placement in the general population. Recently, a female juvenile who was being processed into the facility cut herself with a razor while she was in a holding room bathroom. WCJDF's direct care staff (generally called "juvenile group leaders" in this detention facility) fail to make regular visual inspections of youth who are locked in their rooms for disciplinary reasons or overnight while they sleep. Sometimes youths have been forced to urinate in cups or on the floor because staff did not respond to their requests to use the toilet in a timely manner.

The facility also fails to adequately support and supervise the direct care staff. Staff are left to function on their own devices and as a result, staff members have completely different and inconsistent methods and standards for supervising and disciplining youths. Most of the staff do not have a copy of the facility's policy and procedures manual. Furthermore, the manual itself is incomplete and inadequate to ensure proper operation of the facility. The overall purpose of the disciplinary system is unclear to the detention facility staff. During our interview with staff, many did not know why they were implementing certain

practices (e.g., requiring youth to not talk during television watching periods, requiring entire units to stand silent in front of their rooms prior to any movement of the juveniles) and stated that many of the practices occurred because of "tradition."

Additionally, there is a substantial lack of positive interaction between the direct care staff and the juveniles in their charge. The majority of direct care staff do not interact with the youth they supervise. Most interactions between direct care staff and juveniles are limited to giving orders. Staff spend much of their time observing the juveniles watch television. Many of the staff routinely speak to the juveniles in their care in an explicitly disparaging manner, cursing, and/or yelling at them. We received numerous complaints that staff argue and fight among themselves in front of the juveniles, eat in front of juveniles at times when they cannot eat, and disrupt juveniles' ability to sleep by talking loudly and playing music. Inappropriate methods of supervision defeat the rehabilitative purpose of the juvenile detention facility and endanger the safety of the juveniles housed therein.

5. **Inadequate training**. All levels of staff at the facility are inadequately trained. Intake workers lack training in proper screening procedures. Direct care staff (i.e. juvenile group leaders) have little or no training in crisis management, de-escalation techniques, positive behavior management, counseling, CPR and first aid techniques, proper physical restraint techniques, dealing with victims of physical and sexual abuse, and proper documentation procedures. Finally, supervisors lack training in supervisory skills.

6. **Inadequate documentation**. The documentation process for the entire facility needs to be reviewed and revised. Recent administrative memoranda regarding the keeping of unit logs have been routinely ignored. In the course of our tour, we found logs for entire shifts completed within the first two hours of the shift. Additionally, there is no contemporaneous documentation of visual monitoring of juveniles in isolation.

7. **Deficient intake process**. The intake process at the WCJDF is inadequate and fails to ensure that professionals obtain sufficient information to keep juveniles safe. The facility fails to adequately screen youths at intake for possible placement in non-secure alternative programs. A risk assessment is administered to allegedly "low risk" girls only after their admission to the facility. Additionally, the intake staff questions the youth in the hallway of the facility within listening range of other persons.

8. **Inadequate classification of juveniles**. WCJDF fails to adequately classify juveniles in the facility. The facility has no classification system for housing female juveniles. The

facility does classify boys primarily based on offense, size and age; however, when youths fight or argue the staff often move youth from one living unit to another. The staff often use the older "tougher" living units to "control" younger acting out youth, and in effect negate the entire classification scheme. Lack of adequate classification compromises juveniles' constitutional right to personal safety.

9. **Severe overcrowding.** WCJDF has been chronically overcrowded holding up to 290 juveniles. During our tour the population ranged from 237-244. Some youths sleep on the floor and on bunk beds in the day rooms. Although the facility is supposed to be a short term detention facility, many youths stay at WCJDF for long periods while awaiting transfer to another facility. On April 4, 1994, approximately 25 percent (60 boys) of the 243 boys in the facility had lengths of stay in excess of 50 days. Twenty-nine of the 60 boys had been in the facility for more than 100 days. The facility fails to prevent overcrowding which exacerbates the incidence of juvenile on juvenile violence, and precludes direct care workers from attending to the individual needs of the juveniles. In addition, the facility fails to provide the necessary services (i.e. education programs, mental health services, medical services) which become more critical for those juveniles staying in the facility for an extended duration.

10. **Inadequate general education.** There are serious problems with WCJDF's education program. Many juveniles are being denied access to any education. The following juveniles are routinely excluded from educational programming: (1) youths on isolation status; (2) youths suspended from school for misbehavior; (3) any excess of numbers of youths over 16 in a living unit (apparently education groups can be no larger than 16 youth); and (4) juveniles with special health and mental health needs. Two examples of exclusion which we noted on our tour include the following: an African American youth was excluded from school for over two weeks because he wore his hair in dreadlocks and another youth who had a history of psychiatric problems was permanently banned from school because he was acting out -- this individual spent his entire day doing nothing in the his unit dayroom. At the time of our investigative tour, nearly 21 percent of the entire population of the facility were either watching television, sitting silently on chairs, or were locked in their rooms during the school day. Juveniles who were excluded from the school were not receiving any alternative educational programs.

Furthermore, juveniles generally do not receive credit by outside schools for courses taken at WCJDF. The facility also does not offer a GED program for older juveniles. There are few reading materials and no educational materials of any kind available in the living areas, where some juveniles spend roughly

22 out of 24 hours a day. Students do not have individualized plans. In fact, educational problems, goals, interventions, and progress are not recorded in the juveniles' records.

There is little coordination between the school and the detention facility. The educational evaluation of the juveniles at the school, if one is ever done, is not available to WCJDF staff. Furthermore, the facilities have different, conflicting disciplinary philosophies.

WCJDF's failure to provide resident juveniles with educational services similar to the educational services provided to children in the community violates the juvenile's rights under the Equal Protection clause of the Constitution. Additionally, the failure to provide all juveniles with access to education violates their rights.

11. **Special education services.** Juveniles at the WCJDF are not receiving appropriate special education services. We were informed by the principal of the school that only 18 youths in the entire population were special education eligible. In similar juvenile facilities it is not unusual for 35-50 percent of the population to be eligible for special education services. The facility does not develop individualized education plans for juveniles with disabilities and has not developed an individualized curriculum designed for youths with special education needs. The school does not give juveniles assessments that might reveal the reasons for truant behavior, such as the presence of Attention Deficit Hyperactivity Disorder, a receptive and/or expressive language disorder, a visual-perceptual skills deficit, or intellectual limitations. As discussed above, juveniles who exhibit severe behavior problems are routinely left in the housing units without any educational programming.

These conditions violate the constitutional and statutory rights of the juveniles confined in WCJDF. The State of Michigan, the Detroit Public School system, and Wayne County are in part or in whole responsible for these practices which violate the Constitution, Section 504 of the Rehabilitation Act, and the Individuals with Disabilities Education Act.

12. **Inadequate access to telephones and visitation.** The juveniles do not get reasonable access to use of telephones. Currently one of the two counseling staff must approve every telephone call. This system hampers the ability of juveniles to contact their counsel and their families.

Visitation at the facility is inadequate. Although juveniles receive daily visitation, we received numerous complaints regarding visits being cut off after half an hour. We also received complaints that the visitation schedule (Monday to Friday from 3:30 to 4:30 p.m.) is inconvenient for parents who

work during the day. Additionally, the visitation is held on the unit where other juveniles can disrupt visitation. No provision for additional visitation is made for juveniles with extended lengths of stay.

13. **Inadequate access to courts.** The facility fails to provide juveniles with the fundamental constitutional right of access to the courts by failing to provide juveniles with adequate assistance from persons trained in the law to assist them in filing meaningful legal papers and failing to provide them with adequate legal materials.

14. **Inadequate detention case management.** The facility does not have an operable detention case management system which identifies specific barriers that prevent the timely processing of youth through the detention process. Additionally, the facility fails to inform juveniles of the names of their counsel, their hearing dates, and other essential information regarding their cases and their detention at WCJDF.

II. General Medical, Mental Health Care, Dental Health Care, and Suicide Prevention Measures Are Seriously Deficient.

1. **Deficient screening procedures.** WCJDF's procedures for screening juveniles upon admission for health and mental problems are seriously deficient. The detention facility lacks a written policy regarding screening procedures. Upon arrival, youth are informally screened by intake personnel who are inadequately trained to identify youth with special medical and mental health needs. The information obtained during intake is not documented in a standard fashion.

Within three to four hours of admission, juveniles are screened by a nurse. On occasion, a youth will be placed on a unit before seeing a nurse. For each juvenile, a nurse will complete an "Admission Data and Screening Assessment" form recording vital signs, history of any medical problems, and history of prescription medications. A PPD-TB skin test for tuberculosis and a VDRL test for syphilis are also conducted for each juvenile. HIV testing is available only upon request. Some of the youth we spoke with were unaware of the availability of HIV testing.

During our review of medical records, we found that several of these forms contained blank sections or conflicting information. In addition, some records indicated a lack of follow-up. For example, although one youth complained of exposure to HIV, he was not offered a test. Adequate screening procedures and follow-up are necessary to prevent newly-admitted juveniles who pose a health or safety threat to themselves or

others from entering the general population and to ensure that a juvenile's medical and mental health needs receive timely attention.

2. **Inadequate access to general medical care.** WCJDF's procedures for providing juveniles with access to general medical care is deficient. Currently, juveniles must ask direct care staff to be placed on sick call when they are ill. Youth have reported that WCJDF staff screens their requests and often refuses to place them on sick call.

3. **Deficient dental care.** WCJDF provides no dental services on-site. The detention facility does not provide oral screening, oral hygiene, or examinations. Off-site dental care is available only on an emergency basis.

4. **Inadequate mental health assessments.** WCJDF fails to provide adequate mental health assessments. The facility provides specialized mental health assessments through the services of Dr. Silverman, a child and adolescent psychiatrist, and crisis intervention services contracted through the Clinic for Child Study. Youth are referred by WCJDF staff to Dr. Silverman and the crisis intervention staff at the Clinic for Child Study for evaluation.

Dr. Silverman provides consultation on-site three hours per week and 24 hour a day emergency coverage. He is asked to evaluate "ten or more" youth during this three-hour period and to arrange psychiatric hospitalization of at least one youth per week. The crisis intervention staff is supposed to assess each youth who is referred on a daily basis. However, due to the number of youth requiring their services, daily assessments are limited to the most disturbed youth.

The Clinic for Child Study estimates a 30 percent incidence rate of mental health problems among WCJDF detainees. WCJDF does not have a sufficient number of psychologists or psychiatrists available to meet the mental health needs of its juvenile detainees or even to assess their need for such services. In addition, WCJDF fails to provide youth with direct access to mental health professionals.

5. **Inadequate psychotropic medication practices.** The policies and procedures for administering and monitoring psychotropic medication at WCJDF are inadequate. WCJDF lacks a system for monitoring medication side effects. While Dr. Silverman evaluates all youth receiving psychotropic medication, none of the medical records reviewed during our tour revealed documentation of medication side effect monitoring by the WCJDF medical staff. Additionally, staff lacks training on how to recognize side effects of psychotropic medication. Youth

must be evaluated regularly by WCJDF medical personnel for possible side effects.

Our review of medical records also revealed that WCJDF medical personnel have failed to refer youth to Dr. Silverman for evaluation where their history suggests a need for psychotropic medication. WCJDF personnel have also failed to obtain laboratory reports requested by treating psychiatrists. Records indicated that verbal orders are not consigned. In addition, WCJDF has not routinely provided counseling to youth taking psychotropic medications.

6. **Inadequate mental health counseling**. WCJDF's policies and procedures regarding counseling and staffing patterns are inadequate to meet the needs of detained youth. The detention facility currently employs two counselors who see ten residents a day. During the course of interviews, counselors indicated that they do not have enough time to see all the youth requiring counseling. Additionally, the facility fails to address the specialized needs of recognized groups of youths such as, victims of sexual and physical abuse and youths with extended lengths of stay.

7. **Inadequate suicide prevention measures**. WCJDF's policies and procedures for suicide prevention are inadequate. Records reveal that WCJDF has failed to provide youth who have attempted suicide with immediate mental health attention. For example, a juvenile detainee was hospitalized from November 3, 1993, through December 17, 1993, after attempting suicide by tying his shoe strings around his neck. On December 27, 1993, the treating psychiatrist recommended that the youth be sent to a mental hospital because he had suicidal ideations. Four days later, the youth was found hanging by his shoelaces from a showerhead. Staff promptly cut him down and saved his life. There is no evidence that the youth received mental health attention until two days later.

Youths on the suicide precautions list are not assessed at appropriate intervals. Another problem we noted is the revision of the suicide precautions list. Currently, the crisis intervention staff revises the suicide precautions list on a weekly basis. As the mental status of a juvenile may vary greatly from day to day, weekly assessments reflecting a suicide risk may result in youth spending more time than necessary on suicide watch and thereby, under the current practices of the facility, being forced to sleep in the hall or to miss school. Youth on the suicide precaution list should be re-assessed on a daily basis.

8. **Lack of youth development and rehabilitative programming**. WCJDF has failed to provide appropriate youth development programs. Community meetings, anger control groups, cultural and educational activities on the units are nonexistent.

When youth are not attending school or exercising in the gym, they simply sit and watch television or play cards for hours. Many of the youth we interviewed complained about the lack of activities provided, particularly on days when school is out of session. Appropriate programs outside of the school environment are essential to the treatment and rehabilitation of juveniles in the WCJDF.

9. **Inadequate opportunity for exercise and recreation.** Juveniles in the facility do not receive adequate time for large muscle outdoor and indoor exercise and recreation. Scheduled gym periods are often cancelled. Exercise is necessary for proper growth and physical maturation of juveniles.

10. **Lack of quality assurance.** WCJDF lacks any formal mechanism for ensuring the quality of medical care it provides. There is no periodic review of physician performance. There is no periodic audit of medical records. There is no periodic review of pharmaceutical practices and procedures by a pharmacist. Currently, WCJDF lacks policies and procedures necessary for ensuring that its youth receive adequate medical care.

III. Wayne County Juvenile Detention Facility Has Serious Environmental and Health Deficiencies.

1. **Deficient food handling practices.** Food handling at WCJDF is inadequate. There is no clearly established procedure for serving food to the youth. The manner in which food is served varies from unit to unit. In most cases, food handlers do not wear hair nets, aprons or gloves. They do not wash their hands before opening the foil and plastic tray covers before serving the food. During our tour, we observed food being placed uncovered on tables for inappropriate periods of time prior to being eaten by juveniles. There are also no weekly inspections of the food service areas.

Poor food handling practices result in food contamination. Roaches, worms, rocks, metal, hair, and thermometers are among the foreign objects that have been found in the food. Recently, youth received medical treatment after eating brownies containing metal shavings.

2. **Inadequate lighting.** Lighting throughout much of the WCJDF facility is inadequate. The kitchen area in which food trays are transferred from insulated containers to electric serving carts is poorly illuminated. The lighting levels in many of the rooms and bathrooms on the units are inadequate. Adequate lighting is necessary for sanitation, hygiene and reading.

3. **Inadequate plumbing.** The supply of hot water on the units varies widely ranging from no hot water to water

temperatures exceeding 120 degrees. Properly controlled water temperatures are necessary to promote good hygienic practices and to prevent burning or scalding.

4. **Inadequate ventilation.** The grills over the heating and ventilation system ducts are partially blocked in most areas from significant amounts of plaster, debris, dust and other particles. The vents should be kept clear of dust, dirt and debris accumulation as it provides a breeding place for disease causing agents and vermin.

5. **Inadequate housing.** WCJDF lacks a sufficient number of showers to meet the needs of the youth home. Each unit provides two shower facilities. An adequate number of shower facilities is essential for maintaining good health and preventing disease.

6. **Inadequate refuse storage.** Solid waste is not properly stored at WCJDF. During our tour, we found the lids of the bulk containers open and the surrounding grounds littered with trash. Proper storage of refuse is necessary to minimize odors, and to prevent rodent and insect breeding.

7. **Deficient environmental sanitation practices.** Several areas of WCJDF need cleaning. During our tour, we found what appeared to be feces on the ceiling of some rooms, mold on the walls of shower stalls, and toilet paper, paper towels and other debris on the floors of bathrooms. There are no weekly sanitation inspections of the detention facility. Regular inspections and proper response to violations will prevent environmental health problems before they occur.

8. **Deficient clothing exchange practices.** The youth wear underwear worn by other residents. This practice is unsanitary. Clean clothing is exchanged twice a week. During our investigation there was lice infestation on one unit allegedly due to infected underwear. Complete sets of clean clothing should be issued three time per week.

9. **Inadequate insect and vermin infestation control.** WCJDF is infested with rodents and roaches. During our tour, we found dead rodents and roaches near a bait station in the kitchen and roaches under the sink in one of the day rooms. Regular extermination is necessary to control insect and vermin infestation.

IV. <u>WCJDF is Replete With Fire Safety Deficiencies</u>.

The fire safety system at WCJDF is grossly inadequate. WCJDF does not train its personnel in the use of fire protection equipment and how to implement fire plans. During our tour, we found that all staff members did not appear to be familiar with the operation of the standpipe hose and fire extinguishers.

There are no smoke detectors in the building for area smoke detection. In addition, there are a variety of conditions in the youth detention facility which pose additional fire safety hazards to its occupants. For example, the building lacks fire separations on individual floors; the walls which separate the elevator lobbies from the North and South Wings are not adequate smoke barriers; duct penetrations are not provided with dampers; all floors exceed common path of travel distances for providing adequate means of egress out of the building; both stairs discharge in the first floor corridor; there is an open stair from the first floor lobby up to the second floor hearing rooms which should be enclosed; and the doors to the housing units are not smoke resistant.

MINIMUM REMEDIAL MEASURES

To rectify these deficiencies and to ensure that constitutional conditions of confinement at WCJDF are achieved, the following minimum remedial measures should be implemented:

I. Operational, Management, Staffing, and Programming Deficiencies.

1. **Ensuring that juveniles are not abused by staff.**

(a) The facility needs to restate its policy that staff who abuse youth will be permanently terminated. The facility shall not permit any staff who have serious substantiated child abuse charges or has been found to have engaged in abusive conduct (e.g. beating a youth, forcing them to urinate on themselves, stripping them and parading them naked, etc.) to work as youth supervisors or group leaders.

(b) Inform youth and their families (both orally and in writing) of their right to file an abuse claim, and if they desire, to pursue a criminal investigation in alleged serious cases. Provide this information to all youth at intake.

(c) Train all staff regarding child abuse and apprise them of their responsibility to report abuse and to cooperate with abuse investigations.

(d) The independent investigation of alleged abuse needs to be taken out of the line of command of the facility. The County must identify and assign an experienced, independent investigator who works directly for the County Executive who has no prior association with the detention facility and who does not report to the Director of WCJDF. The independent investigator shall forward the complaint to Department of Social Services and immediately conduct a thorough and independent investigation. Furthermore, this independent investigator shall ensure that all

youth have the ability to make a child abuse complaint and log all allegations of abuse.

(e) Interviews with youth regarding abuse allegations should be conducted without the presence of a union representative.

2. **Use of force, discipline, and isolation.**

(a) Train or re-train all staff involved with physically restraining youth in legitimate restraint practices. Each incidence of physical restraint needs to be carefully supervised and the rationale for the restraint adequately documented. Each juvenile restrained should be seen by medical staff after restraint.

(b) Completely restructure the behavior management system to create a new positive behavior management system which rewards juveniles for appropriate behavior. Ensure that this system distinguishes between disciplining juveniles and placing them in room isolation for a short "cooling out" period when they are out of control.

(c) Develop a clearly defined, written discipline code that identifies minor and major infractions and the penalties that a youth might suffer for breaking the rules. Isolation should not be a sanction for minor infractions. Disciplinary isolation should be time-limited and should be based on the results of a due process hearing. The facility needs a due process policy and practice that provides notice, a hearing, and other procedural protections before imposing punishment. Youth who are required to spend any more than two hours in room isolation should be entitled to a due process hearing. The facility should cease all inappropriate use of isolation and "standing track."

(d) Provide juveniles who are in isolation with access to educational programming and exercise.

(e) Adequately monitor all juveniles in isolation or room confinement.

(f) Juveniles who are placed in isolation should be provided with appropriate bedding.

(g) Implement a legitimate and objective youth grievance policy.

3. **Staffing.** Hire additional staff to ensure that direct care staff ratios for waking hours should be one staff to eight youth and one staff to 16 youth during sleeping hours. The 12 living units should have at least six counseling staff. Appoint

unit or floor managers to improve supervision and programs on the living units.

4. **Supervision.**

(a) Ensure that juveniles are adequately supervised, i.e., that direct care staff shall engage in appropriate behavior and shall be closely supervised, that direct staff shall appropriately interact with juveniles, and that they shall adequately monitor the juveniles.

(b) Revise current policies and procedures to ensure proper operation of the facility and ensure that all staff are familiar with these procedures.

5. **Training.** Develop and implement a specific training plan. Direct care staff (i.e. juvenile group leaders) should be trained in, inter alia, crisis management, de-escalation techniques, positive behavior management, counseling, CPR and first aid techniques, proper physical restraint techniques, dealing with victims of physical and sexual abuse, and proper documentation procedures. Finally, supervisors should receive training in supervisory skills.

6. **Documentation.** Ensure that unit logs are kept accurately and contemporaneously, that comprehensive isolation logs are completed, and that visual check of all juveniles locked in rooms are documented. In addition, due process procedures and use of any type of restraints should be documented.

7. **Intake.** Screening should be done in a private area by trained staff. Staff should consistently monitor the detention rooms. The facility should utilize a risk assessment instrument at intake to ensure that low risk youth are sent to alternative facilities or programs.

8. **Overcrowding.** House only an appropriate number of juveniles in the facility.

9. **Detention case management.** Develop a process designed to ensure that all youths stay in detention for the shortest amount of time consistent with public safety.

10. **Classification.** Implement an adequate classification system for all juveniles in its care. Mental health staff should be involved to manage difficult youth and to identify youth for whom alternative placements are needed.

11. **General education and special education.** Ensure that every juvenile in the WCJDF has access to and receive appropriate general education and those who are eligible receive special

education services. Youth with special health or mental health needs should not be denied access to education. Youth with special hair styles should not be denied access to education. Youth on disciplinary room confinement for more than one day should have daily access to education. The school should discontinue the practice of excluding (suspending or expelling) youth with behavioral problems from education. Both the school and the detention facility should work more cooperatively with the detention center to develop joint programs.

12. **Telephones and visitation.** Provide adequate visitation and allow juveniles reasonable access to unmonitored telephone calls to parents, relatives, and attorneys.

13. **Access to courts.** Ensure that juveniles have adequate access to courts, i.e., provide persons trained in the law to assist juveniles in drafting meaningful documents and provide adequate access to legal materials.

II. General Medical Care, Mental Health Care, Dental Care, and Suicide Prevention Measures.

1. **Screening procedures.** Develop policies and procedures requiring intake personnel with health-training to conduct initial screening of a youth upon arrival. Document the need for emergency care, mental status and physical condition in a standard fashion. Ensure that nursing personnel follow up and expand the initial screening. Revise and expand current screening forms. Inform incoming youth of the availability of HIV testing.

2. **Access to general medical care.** Provide youth with unimpeded access to general medical care.

3. **Dental care.** Provide youth with oral screenings, hygiene and examinations. Dental care should not be limited to extractions.

4. **Mental health assessment.** Provide specialized mental health assessments for all juveniles with symptoms of mental illness upon initial screening or referral by staff. Provide sufficient number of psychiatrists and psychologists to perform assessments. Establish quality assurance mechanisms to track the provision of this service. Provide all staff training on recognizing symptoms of mental illness.

5. **Psychotropic medication.** Develop policies and procedures for administering and monitoring psychotropic medication. Ensure that the use of psychotropic medication is reviewed by a psychiatrist on a regular basis. Provide all staff with training on recognizing the side effects of psychotropic

medication. Ensure that youth receiving psychotropic medication are regularly evaluated by medical personnel for side effects.

6. **Mental health counseling.** Provide a sufficient number of counselors to meet the needs of the youth. Ensure direct access for juveniles to mental health professionals.

7. **Suicide prevention.** Develop policies and procedures for emergency mental health intervention. Provide staff training on recognizing verbal and behavioral cues that indicate potential suicide. Revise suicide precaution list on a daily basis.

8. **Programming.** Develop adequate youth development programs. Expand daily activities on the units to include, inter alia, educational activities and clinical groups.

9. **Exercise and recreation.** Provide juveniles with adequate opportunity for exercise and recreation time outside.

10. **Quality assurance.** Develop policies and procedures requiring physician peer review, regular and periodic audits of medical records, regular and periodic quality assurance meetings. Develop policies and procedures requiring on-site review of pharmaceutical practices and procedures by a pharmacist.

III. Environmental Health and Safety

1. **Food service.** Develop written policies and procedures for serving food on the units. Ensure that all food handlers employ hygienic food-handling techniques. Conduct weekly inspections of all food service areas, food preparation areas and equipment, temperature-controlled storage facilities for all foods, and daily checks of refrigerator and water temperatures.

2. **Lighting.** Provide adequate lighting (at least 20 foot candles) in food preparation and service areas, and youth living areas.

3. **Plumbing.** Provide adequate hot water.

4. **Ventilation.** Provide adequate ventilation.

5. **Housing.** Provide an adequate number of shower facilities at the ratio of one shower for every eight juveniles.

6. **Refuse storage.** Ensure that solid waste is stored properly and the areas surrounding the storage containers are free of litter.

7. **Environmental sanitation.** Ensure routine daily cleaning of the living units. Conduct weekly inspections of all facility areas.

8. **Clothing.** Provide all youth with clean clothes on a scheduled three times a week basis. Provide youth with their own underwear.

9. **Insect and vermin infestation.** Ensure regular extermination service for all WCJDF facilities.

IV. Fire safety

1. **Fire safety measures.** Ensure that WCJDF provides adequate fire safety to the juveniles therein and remedies each of the deficiencies identified in this letter. This should include, inter alia,: fully training all staff in the implementation of fire plans and the use of fire protection equipment; reviewing training annually; providing system connected smoke detectors in all housing areas; providing sprinklers throughout the basement and first floor; providing an emergency generator to power emergency lights or provide battery operated emergency lights in the housing areas and the means of egress; providing self-closers or automatic closers on the doors to each housing wing; extending the masonry wall up to the floor slab above, sealing all penetrations and providing smoke dampers where ducts penetrate these walls; ensuring that dampers are operated by smoke detectors in accordance with fire codes; providing a new staircase at each end of the housing wings to eliminate the excessive common paths of travel; providing a one hour fire resistive rated separation wall on the first floor so that the two exit stairs will discharge into the first floor on different sides of the new fire barrier; separating the basement storage areas from the corridor with one hour fire resistive walls with three-quarter hour fire protection rated self-closing doors, and; providing a minimum one hour fire resistive enclosure around the stair penetration from the first to the second floors.

Pursuant to CRIPA, the Attorney General may initiate a lawsuit to correct deficiencies at an institution 49 days after appropriate local officials are notified of them. 42 U.S.C. §1997b(a)(1). Therefore, we anticipate hearing from you before that date with any response you may have to our findings and a description of the specific steps that you have taken or will take to implement each of the minimum remedies set forth above. If you do not respond within the stated time period, we will consider initiating an action against your jurisdiction to remedy the unconstitutional conditions.

Thank you for your cooperation. We look forward to working with you and other county officials to resolve this matter in a

reasonable and expeditious manner. If you or any member of your staff have any questions, please feel free to contact Iris Goldschmidt, Trial Attorney, Special Litigation Section, at (202) 514-6264 or Tawana Davis, Trial Attorney, Special Litigation Section, at (202) 514-6534.

Sincerely,

Deval L. Patrick
Assistant Attorney General
Civil Rights Division

cc: Jennifer Granholm, Esquire
Corporation Counsel

Mr. Ricardo A. Solomon
Chairman
Wayne County Commission

Mr. Warren C. Evans
Director
Wayne County Juvenile Detention Facility

Mr. Robert Ficano
Sheriff, Wayne County

Saul Green, Esquire
United States Attorney
Eastern District of Michigan

Alan Gershel, Esquire
Chief Assistant/Chief of Criminal Division
Eastern District of Michigan

The Honorable John Engler
Governor of the State of Michigan

The Honorable Frank J. Kelley
Attorney General
State of Michigan

Robert E. Schiller, Ph.D.
Superintendent of Public Instruction
Michigan Department of Education

The Honorable Dennis Archer
Mayor of the City of Detroit

The Honorable Phyllis A. James
Corporation Counsel
City of Detroit

Dr. David Snead
Superintendent of Schools
Detroit Public Schools

The Honorable Richard Riley
Secretary
United States Department of Education

Ms. Judith E. Heuman
Assistant Secretary
Office of Special Education and Related Services
United States Department of Education

Mr. Tom Hehir
Director
Office of Special Education Programs
United States Department of Education