

IN THE UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF PUERTO RICO

THE UNITED STATES OF AMERICA,

Plaintiff,

v.

COMMONWEALTH OF PUERTO RICO;

The Honorable PEDRO ROSSELLO,  
Governor of Puerto Rico in his  
official capacity;

THE JUVENILE INSTITUTIONS  
ADMINISTRATION;

NYDIA COTTO VIVES, Secretary  
of Corrections and  
Rehabilitation  
in her official capacity;

MIGUEL RIVERA, Administrator,  
Juvenile Institutions  
Administration;  
in his official capacity;

VICTOR FAJARDO, Secretary,  
Department of Education, in  
his official capacity;

JOSE A. FUENTES AGOSTINI,  
Secretary, Department of  
Justice for the Commonwealth  
of Puerto Rico, in his  
official capacity;

CARMEN L. RODRIGUEZ,  
Secretary, Department of  
Services to the Family  
(formerly Social Services  
Dept.), in her official  
capacity;

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U.S. DISTRICT COURT  
SAN JUAN, P.R.

CIVIL ACTION NO. 94-2080 (CC)

U.S. v. Puerto Rico



JI-PR-004-012

DR. CARMEN FELICIANO VDA. DE MELECIO, Secretary of Health, Department of Health, in her official capacity;

DR. JOSE ACEVEDO MARTINEZ, Administrator, Mental Health and Anti-Addiction Services Administration (formerly Anti-Addiction Services Dept.), in her official capacity;

ANGEL VICTOR MARTINEZ, Director, Cabo Rojo Industrial School (also known as Mayaguez) and Detention Center, in his official capacity;

FRANCISCA APONTE, Director, Ponce Central Training School, in her official capacity;

ANGEL VAZQUEZ, Director, Ponce Detention Center for Girls and Ponce Industrial School for Girls and Boys, in his official capacity;

DANIEL VAZQUEZ TORRES, Director, Guaynabo Training School, in his official capacity; and

JOSE SANTOS, Acting Director, Central Metropolitan Training School of Bayamón, in his official capacity;

Defendants.

AFFIDAVIT OF ORLANDO L. MARTINEZ

I, Orlando L. Martinez, being duly sworn, state:

1. Pursuant to ¶ 42 of the partial consent decree filed

with the Court in August 1994 in the above-captioned case and entered as an order of the Court on October 7, 1994, I was named to serve as the Monitor to oversee defendants' compliance with agreed-upon remedies to address two emergency issues in Puerto Rico's juvenile justice facilities -- overcrowding and mental health service deficiencies. In this capacity, I have filed reports with the Court on November 3, 1994, May 16, 1995, April 16, 1996, January 9, 1997, and February 25, 1997 regarding defendants' compliance with the Court's October 1994 Order.

2. If the proposed Settlement Agreement is entered as a court order, I will also be named as Monitor for all of the conditions in the facilities. In anticipation of this, my staff and I have been periodically monitoring all conditions in all of the facilities at issue in this case. During monitoring visits to facilities, I personally observe conditions at the facility, interview staff and juveniles, and inspect relevant documents.

3. In connection with plaintiff's Motion for Entry of the Settlement Agreement, plaintiff's counsel has asked me to prepare this affidavit regarding my knowledge of current conditions at the facilities.

4. In assessing the care and treatment of juvenile offenders in the facilities, I have utilized the professional standards in the field; the remedial measures proposed in the proposed settlement agreement; and the experience in juvenile corrections I have gained during my 34 years working in this field.

5. As will be discussed in further detail below, there are a number of deficiencies in the facilities throughout the system. I have reviewed the settlement agreement submitted to the Court. In my opinion, the remedial provisions in the settlement agreement are narrowly tailored and are the necessary and least intrusive remedial measures to correct the deficiencies in the system.

Juveniles Are Not Safe

6. I believe that the settlement agreement is needed because juveniles throughout the system face life-threatening and dangerous conditions every day. To put it plainly, juveniles in facilities run by the Juvenile Institutions Administration (AIJ) are not safe. Since 1993, two juveniles have committed suicide and two juveniles have been killed by other juveniles in AIJ facilities. In addition, on June 3, 1997, a juvenile at Mayaguez suffered multiple stab wounds at the hands of two other juveniles and required hospitalization for several days. Similarly, in July, 1997, a juvenile at Guaynabo was hospitalized for stab wounds inflicted by other juveniles. Between February and May, 1997, there were four instances of sodomy and sexual assaults at Cabo Rojo Detention Center. In that same time period, there were 5 instances of sodomy and sexual assaults at Mayaguez. On June 6, 1997, a guard at Cabo Rojo Detention Center broke a juvenile's elbow with a broom handle after the juvenile used bad language. As discussed below, a number of different areas in the settlement agreement address these and related problems.

7. The settlement agreement has special provisions to address problems at Bayamon, where recent juvenile-on-juvenile violence has increased to crisis levels. In June 1997, a juvenile was beaten and stabbed to death by 13 other juveniles. Earlier in 1997, a juvenile was stabbed by another juvenile 16 times, resulting in hospitalization. A third juvenile was stabbed in the hand, resulting in hospitalization for the resulting tendon damage.

New Construction and Capital Improvements to Existing Facilities

8. The settlement agreement contains a number of provisions requiring defendants to build new facilities and tear down and renovate others. In my opinion, these remedial measures are necessary to address the deficient conditions that exist in the facilities and will ensure that juveniles are confined in buildings that are safe.

9. Throughout the system, facilities are poorly maintained. For example, Bayamon, which is only four years old, is literally being destroyed by juveniles who are not being controlled by institutional personnel. At Bayamon, staff have failed to intervene when juveniles have broken light fixtures and smoke detectors, destroyed plumbing, chipped cement, and defaced the facility with graffiti. Juveniles have even removed iron supports from inner walls and dismantled iron gates without staff intervention or sanction. During one recent inspection, staff failed to intervene while a juvenile destroyed a cement table in his cell while one of my staff was present on the unit. Although

problems with the physical plant are most apparent at Bayamon, similar problems with the physical plant at Cabo Rojo detention and training school, Guaynabo and Ponce CTS are also egregious.

10. Throughout the system, facilities are not clean. In many places, vermin such as cockroaches, mosquitos, and rats are found in juveniles' rooms. For instance, in June 1997, rats and cockroaches were observed at the Cabo Rojo Detention Center, where standing pools of water served as fertile breeding grounds for mosquitos. Living conditions at Cabo Rojo are horrible. The use of this facility should be discontinued as quickly as possible. Similarly, in both January and April 1997, cockroaches were observed climbing the walls throughout the living units at Bayamon and mosquitoes were in abundance, probably due to the many standing pools of water throughout the living units. Many rooms cannot be occupied because there is standing water on the floor due to plumbing destroyed by the juveniles, resulting in double or triple bunking in rooms designed to house only one juvenile.

11. Current physical plant design does not facilitate personal contact and interaction between staff and juveniles. For instance, at Bayamon, security staff are isolated and separated from juveniles in a central control center, where they observe juveniles from afar and manage the electronic security systems. Juveniles are padlocked in groups of 16 into housing units with no staff present. There are a number of areas in the day room and bedrooms that cannot be observed by staff. At

night, because the lighting has all been broken, the rooms are in the dark and staff cannot see into them from the control center. Juvenile-on-juvenile violence in these areas is not just a risk, it is a reality. Although one of the goals of confinement in the facilities is rehabilitation, due to the failure of staff to interact sufficiently with juveniles, rehabilitation is inadequate. Caseworkers and other social service staff do not have offices anywhere near where the juveniles are housed. AIJ has not designed any programs to correct this deficiency.

12. Inadequate ventilation and acoustical systems at Bayamon result in extremely noisy and unhealthful living environments. In April 1997, the noise levels at Bayamon were so loud that a normal conversation could not be held.

#### Fire Safety

13. The settlement agreement contains a number of provisions concerning fire safety. In my opinion, these remedial measures are necessary to address the unsafe fire conditions that exist in the facilities and will ensure that juveniles are confined in buildings that are safe.

14. Unsafe fire conditions exist throughout the system. For instance, at Bayamon, a number of rooms cannot be occupied due to demolition by fire. Many sockets throughout the facility have been shorted out by the juveniles. Electrical extension cords with bare wire ends used to ignite material to smolder for mosquito control lie in standing puddles of water. Smoke damage is obvious throughout the facility. At Guaynabo CTS, bare wires

coming out of switch boxes and electrical extension cords crossing foot paths are an obvious fire safety concern. In June 1997, Cabo Rojo Detention Center did not meet fire and safety standards.

15. None of the facilities have weekly or monthly fire or safety inspections by qualified inspectors.

16. None of the facilities have written evacuation plans in the event of a fire or major emergency.

17. At Mayaguez, electronically operated exterior doors to the living units are broken. To open and close these doors requires that they be pushed and pulled manually, which is an obvious fire safety hazard. This problem is compounded by the fact that the interior doors to the juveniles' housing units are chained and locked. In a fire emergency, the locks would need to be manually opened by staff to release confined juveniles. This combination of chained and locked interior doors and broken exterior doors presents a very dangerous situation.

18. In January 1997, the majority of the electronic gates to the pods in living units at Bayamon were broken. Staff had wrapped chains around the gate and padlocked the juveniles into their living units. Bayamon professional staff report and in March 1997 we observed that staff could not find the keys to the locks or the keys were in the possession of someone out of the living unit. The obvious risk of harm to a juvenile locked in a room with others, both from peer violence and from a fire safety perspective, is obvious. But the staff's failure to locate keys

also prevents professional staff at Bayamon from visiting juveniles in their living units.

#### Policies and Procedures

19. The settlement agreement contains a number of provisions concerning policies and procedures. In my opinion, these remedial measures are necessary to address the deficiencies in the facilities.

20. With the exception of the medical program in the facilities, the AIJ has few policies and procedures that guide facility and program operations. Those that are written are inadequately drafted and inconsistently applied. For instance, through out the system, policies and procedures for searches of the facilities, juveniles, staff, or vehicular traffic into the facility to control contraband have been directly copied from institutions in other States with no adaptation to the conditions in the facilities in Puerto Rico. As a result, contraband comes into the facilities undetected. Juveniles have attacked each other with knives, shanks, and other lethal weapons. During a search for contraband at Bayamon, staff discovered hedge clippers in one juvenile's room. At Bayamon, staff report that juveniles regularly ingest illegal drugs and as many as 20 percent of the population have tested positive on drug tests. Some of the life-threatening violence at Bayamon occurred when juveniles were under the influence of drugs.

21. System wide, there is no system of regular review of facilities and programs.

### Staffing and Staff Training

22. The settlement agreement contains a number of provisions concerning staffing and staff training. In my opinion, these remedial measures are necessary to address the insufficient numbers of staff in the facilities and the problems with inadequately trained staff in the facilities.

23. System wide, there are an insufficient number of custodial staff to adequately supervise juveniles. For instance, in June 1997, 9 custody staff supervised 110 juveniles at Cabo Rojo Detention Center. Administrators complain that they have an insufficient number of staff at Bayamon, Ponce Industrial School, and the new detention center at Guaynabo.

24. High staff absenteeism and the failure of staff on duty to be present in areas where juveniles are housed are causing the problem with an insufficient number of custodial staff to supervise the juveniles. Because staff are not present to supervise the juveniles, juveniles suffer great harm from peer violence, as discussed above.

25. Throughout the system, the management of personnel is poor, resulting in critical problems with recruitment and retention, staffing of programs, employee promotion and employee discipline. Job descriptions are inadequate or nonexistent throughout the system.

26. In particular, system wide, staff training is inadequate. For instance, on April 22, 1997, a maintenance man at Bayamon left a 5 pound hammer unattended; a juvenile took the

hammer and used it to break the locks off of doors confining 10 other juveniles. Staff throughout the system are not properly trained in suicide intervention. For instance, when staff discovered a juvenile hanging at Humacao Detention Center, they did not cut the child down and left him hanging for several hours until pictures could be taken. It is possible that the child could have been resuscitated if proper suicide prevention protocols were implemented. Staff at several facilities cannot locate keys to locks on cell doors. Staff throughout the system fail to search visitors and fail to ask for identification upon entry to the facilities. Staff throughout the system fail to intervene when juveniles act out. The lack of a trained workforce is one of the most critical problems in the facilities and throughout the AIJ.

#### Classification

27. The settlement agreement contains a number of provisions concerning classification. In my opinion, these remedial measures are necessary to address the systemic deficiencies in which weak, young and vulnerable juveniles are not protected from their stronger, older and more predatory peers.

28. Within facilities, there are no procedures for classifying juveniles for housing assignments. Facilities place juveniles where there are available bed spaces. At Mayaguez, juveniles themselves select their housing unit.

29. The failure to classify results in vulnerable juveniles

being housed with older, more predatory juveniles. For instance, in June 1997, 13 juveniles at Cabo Rojo Detention Center were being housed in a cell designed for four. One 12 year old and one 13 year old were housed in this cell.

#### Basic Care

30. The settlement agreement contains a number of provisions concerning basic care. In my opinion, these remedial measures are necessary to address deficiencies in the provision of basic care to the confined juveniles.

31. In some facilities, juveniles sleep on the floor on stained and torn mattresses without mattress covers; blankets, pillows, linens and towels are not provided. For instance, in June 1997, juveniles at the Cabo Rojo Detention Center were sleeping on urine stained mattresses without covers. Mattresses in overcrowded cells were hanging from windows and doors because floors were wet and dirty. In facilities where linens and towels are provided, they are not cleaned on a regular basis.

32. In most facilities, there is no housekeeping plan for the facility. As a result, bathrooms are extremely unsanitary; discarded food and other trash is strewn on the floor and walls. This poses an obvious health hazard as well as an attraction for vermin of all types.

33. In most of the facilities, juveniles are not provided clean bedding and towels.

34. System wide, personal care items are sporadically provided to juveniles.

Mental Health and Substance Abuse Care

35. The settlement agreement contains a number of provisions concerning mental health and substance abuse care. In my opinion, these remedial measures are necessary to address deficiencies in the provision of mental health and substance abuse care to the confined juveniles.

36. System wide, there are insufficient mental health professionals to address the mental health needs of the juveniles. Because of insufficient numbers of qualified mental health professionals, juveniles with mental health problems may go undetected. Further, juveniles who develop mental health problems due to the environment in the facilities (such as Post Traumatic Stress Disorder), may also not be served.

37. System wide, defendants fail to adequately treat juveniles with mental illness. Numerous self-destructive acts occur daily throughout the system. For instance, at Bayamon, juveniles continue to cut themselves without staff intervention or appropriate treatment. In April 1997, a juvenile at Bayamon indicated that he has suicidal thoughts and has previously attempted suicide, but that he has not been seen for his mental health problems while confined at Bayamon. During that same monitoring visit, two juveniles at Bayamon cut their legs with a razor. Staff did not respond to these juveniles; no immediate medical care was provided.

38. System wide, juveniles are not provided individualized treatment plans for mental disabilities. Treatment plans, where

they exist, do not include group, family, and individual therapy. Juveniles in need of services due to mental illness are not provided adequate therapy, counseling, treatment planning and follow-up.

39. The Department of Health and ASSMCA are failing to provide adequate treatment of substance abuse. For instance, staff at Cabo Rojo Detention Center reported in June 1997 that they receive about 20 juveniles a month who are experiencing withdrawals from drug or alcohol use. Only four juveniles have ever been referred to ASSMCA for treatment; staff report that services provided by ASSMCA are insufficient to meet the needs of the center's population. Most juveniles with substance abuse problems do not receive any treatment for these problems while confined in the facilities.

#### Disciplinary System

40. The settlement agreement contains a number of provisions concerning the disciplinary systems in the facilities. In my opinion, these remedial measures are necessary to address systemic deficiencies with respect to discipline in the facilities.

41. Security and control is a major problem throughout the system. There is a lack of discipline and control of both staff and juveniles. As described in the discussion on defendants' failure to protect from harm, uncontrolled juveniles have been permitted to inflict serious, indeed mortal, wounds on their peers as a result of this critical problem. The problem with

uncontrollable juveniles is especially acute at Mayaguez and Bayamon, where living units war with each other. The unit wars at Mayaguez and Bayamon probably result from poor staffing, poor staff training, poor building design, the lack of maintenance of the building, the lack of a disciplinary system, and the lack of programs to reduce the juveniles' idle time in the institution.

42. At Bayamon, juveniles climb onto the roof of the facility and shut off the breakers that supplies the staff with air conditioning in their control centers. At the Ponce Industrial School, during a monitoring visit in 1996, one female juvenile exposed her breasts and another exposed her genitalia to my staff. While we were interviewing custodial staff, a female juvenile confined in her housing unit performed oral sex on a male juvenile who was standing at the bars to her unit. My team also observed male juveniles masturbating for the female juveniles.

43. Juveniles at Bayamon assault staff as well as their peers. For instance, during our monitoring visit to Bayamon in January 1997, we witnessed a juvenile, who has a mental illness, throw a glass of Clorox on a staff member; later that same day, the juvenile obtained a bottle of insecticide and sprayed a staff member with it. The following day, a juvenile threw two cups of urine on a social worker.

44. Staff in the institutions are also not controlled. For instance, staff at Bayamon refuse to enter the living units of the juveniles because they are afraid of the juveniles. The

doctor at Bayamon refuses to see juveniles on the living units because he was hit on the head by a juvenile during such a visit. Large groups of juveniles are therefore left unattended for most of the day and night. Staff reportedly destroyed their time clock used to verify work hours because they had been asked to report to work on time. Kitchen staff at Bayamon protest because they were asked to clean the kitchen. Custodial staff at Bayamon refuse to bring juveniles to appointments with counseling personnel, such as social workers. One Bayamon social worker had great difficulty getting a juvenile who had been sodomized removed from the living unit so that he could be examined by a doctor. Professional staff at Bayamon report that direct care staff at Bayamon lack a commitment to working with juveniles and are not trained to interact with juveniles who are acting out. There is no evidence that employees are disciplined for their refusals to do their jobs.

45. System wide, there are no written policies or procedures restricting the use of physical force by staff to instances of justifiable self-defense, protection of others, protection of property, and prevention of escapes. As a result, staff use physical force in situations when other less intrusive means are appropriate. For example, as mentioned before, staff at Cabo Rojo recently fractured a juvenile's elbow with a broom handle for cursing.

46. At Bayamon, on January 19, 1997, while a social worker was in a residential building at Bayamon, staff used tear gas on

the juveniles. On February 18, 1997, 16 juveniles entered the housing unit's central control area without permission. The juveniles were upset because they had not received outdoor exercise. Staff sprayed gas into the housing unit and entered the area in riot gear wielding batons. Several juveniles were struck with batons, resulting in serious injuries, as the juveniles attempted to return to their pods. One juvenile suffered a laceration on his head requiring 6 sutures and a laceration around one of his eyes. Seven juveniles suffered shoulder and rib injuries. The injured juveniles were not transported to the local hospital room for emergency treatment for nearly two hours following the incident.

47. I have identified a number of poor practices in the use of restraints in the facilities. For instance, at the Ponce Industrial School, which is surrounded by a security fence, juveniles are transported for medical services and for meetings with their social workers in handcuffs and/or leg irons. The facilities have no written policies and procedures that provide that restraints are never applied as punishment and are applied only with the approval of the facility Director or designee.

48. Isolation rooms are not located in areas that permit staff to adequately supervise juveniles. Staff at Mayaguez fail to check juveniles in isolation at sufficiently frequent intervals.

49. AIJ fails to utilize isolation rooms properly. For example, the facilities are unable to protect from harm juveniles.

who have been identified by their peers as snitches and juveniles who are being continually abused sexually by their peers. Such juveniles are placed in isolation.

Protective Custody

50. There is a provision in the settlement agreement regarding protective custody. This provision is necessary to address the systemic deficiency regarding protective custody status in the facilities.

51. Juveniles who are known by their peers as snitches and juveniles who continue to be abused sexually by their peers cannot be protected from harm under current conditions in the facilities unless they are placed in isolation for the duration of their confinement. Such juveniles are, in effect, being punished for the system's failure to afford sufficient levels of security because juveniles in the isolation cells are separated from other juveniles and do not receive the same level of services as juveniles in the general population.

Educational and Vocational Services - General Population

52. There are several provisions in the settlement agreement regarding educational and vocational services for juveniles in the facilities. In my opinion, these provisions are necessary to address the systemic failures to provide adequate educational and vocational services to the confined juveniles.

53. Throughout the system, juveniles are not provided a minimum of six hours, five days a week, 10 months per year, of educational instruction, as required by the proposed Settlement

Agreement. For instance, at Bayamon, during our January 1997 monitoring tour, only 5 juveniles were in school out of the approximately 190 juveniles confined at the facility. In June 1997, the Director of Mayaguez reported that only 40% of the juveniles at that facility receive educational services.

54. System wide, a significant number of teachers are not licensed or certified in the subject matters that they are teaching.

55. Teacher absences, with no contingency plan for substitute teachers, contributes to the failure to provide adequate educational services to the juveniles.

56. System wide, juveniles are not assessed for academic and vocational needs when they enter the facility. As a result, individualized educational and vocational plans are not provided to each juvenile during confinement in the institutions.

#### Educational and Vocational Services - Juveniles with Disabilities

57. There are several provisions in the settlement agreement regarding educational and vocational services for juveniles with disabilities in the facilities. In my opinion, these provisions are necessary to address the systemic failures to provide adequate educational and vocational services to confined juveniles with disabilities.

58. System wide, an unusually low number of juveniles have been identified with special educational needs. For instance, in October 1995, only six juveniles out of a total population of 192 juveniles at Bayamon had been identified as needing special

education. System wide, there is a failure to assess, detect, and provide appropriate services for juveniles with special educational needs.

59. System wide, juveniles are not provided reading materials on their living units.

#### Recreation

60. There are two provisions in the settlement agreement regarding recreation. In my opinion, these provisions are necessary to address the systemic failures to provide adequate opportunities for exercise.

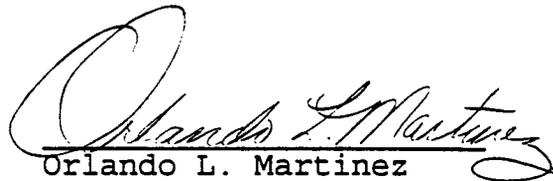
61. Juveniles are not receiving sufficient exercise during confinement at the facilities. For instance, in June 1997, juveniles detained at Cabo Rojo Detention Center and Mayaguez were not receiving one hour of daily exercise, as required by this Court's Order of October 7, 1994. Instead, most of these juveniles spend 24 hours per day locked in their cells. In January 1997, juveniles at Bayamon were also spending 24 hours a day locked in their cells. A monitoring re-tour of Bayamon in April 1997 showed that some juveniles were receiving one hour of daily outdoor exercise, but juveniles in one housing unit were only receiving outdoor exercise sporadically. Staff shortages, group room searches, and juvenile uprisings continued to cause cancellation of outdoor exercise throughout the facility. Juveniles at Guaynabo only receive indoor exercise due to staff shortages. The lack of exercise is related to the lack of discipline and control of the juveniles that each of these

facilities is currently experiencing.

Conclusion

62. System wide, the facilities do not have environments that are conducive to rehabilitation. Although institutional overcrowding has been significantly reduced during the years that I have been monitoring conditions in the facilities, population reductions alone will not fix the problems at the facilities. Program operations must now become a priority throughout the system so that the facilities can be transformed from warehouses into facilities that meet the purposes for which they were designed.

I declare under penalty of perjury that the foregoing is true and correct.

  
Orlando L. Martinez

Executed on Aug 2, 1997

Sworn to before me this 2<sup>nd</sup>  
day of August, 1997

  
Notary Public



My Commission Expires  
September 28, 1998