



**Investigation of the Arthur G. Dozier School for Boys and the
Jackson Juvenile Offender Center, Marianna, Florida**

United States Department of Justice
Civil Rights Division

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Summary of Findings

Despite Florida's statewide system of oversight of its juvenile justice facilities, we found harmful practices at both the Arthur G. Dozier School for Boys ("Dozier") and the Jackson Juvenile Offender Center ("JJOC")¹ that threatened the safety and wellbeing of youth. Florida's oversight system failed to detect and sufficiently address the problems we found at Dozier and JJOC. We find that many of the problems we identified at Dozier and JJOC are the result of a systemic lack of training, supervision, and oversight. These problems may well persist without detection or correction in other juvenile facilities operating under the same policies and procedures and subject to the same oversight process that allowed the failures at Dozier and JJOC to persist until a budgetary crisis forced their closure. As such, to inform Florida's Department of Juvenile Justice's ("DJJ") continued care of the juveniles within its youth facilities, we discuss our findings at Dozier and JJOC in this Report. Our findings remain relevant to the conditions of confinement for the youth confined in Florida's remaining juvenile justice facilities.

The youth confined at Dozier and JJOC were subjected to conditions that placed them at serious risk of avoidable harm in violation of their rights protected by the Constitution of the United States. During our investigation, we received credible reports of misconduct by staff members to youth within their custody. The allegations revealed systemic, egregious, and dangerous practices exacerbated by a lack of accountability and controls. We found the following threats to the safety of the youth:

- Staff used excessive force on youth (including prone restraints) sometimes in off-camera areas not subject to administrative review;
- Youth were often disciplined for minor infractions through inappropriate uses of isolation and extensions of confinement for punishment and control;
- Staff were not appropriately trained to address the safety of suicidal youth and were often dismissive of suicidal behaviors; and
- The safety of Dozier youth was compromised as a result of their relocation to JJOC, a more restrictive and punitive environment.
- The State failed to provide necessary and appropriate rehabilitative services to address addiction, mental health or behavioral needs, which serve as a barrier to the youths' ability to return to the community and not reoffend.

¹ Both facilities constituted the North Florida Youth Development Center ("NYFDC"). When discussing both facilities, we will use the term NYFDC.

These systemic deficiencies exist because State policies and generally accepted juvenile justice standards were not being followed. We found that NYFDC staff did not receive minimally adequate training. We also found that proper supervision and accountability measures were limited and did not suffice to prevent undue restraints and punishments. Staff members failed to report allegations of abuse to the State, supervisors, and administrators. Staff members often failed to accurately describe use of force incidents and properly record use of mechanical restraints.

These failures violate the Fourteenth Amendment's mandate that youth in custody be adequately protected from harm, undermining public safety by returning youth to the community unprepared to succeed and eroding public confidence. We appreciate the efforts of NYFDC's leadership to correct longstanding deficiencies and its responses to recommendations we made throughout the investigation. In order to avoid another failed facility such as Dozier and to ensure that confined youth are being treated in a manner consistent with the Constitution, the State must conduct an accountability review of its remaining facilities with the assistance of consultants in the field of juvenile protection from harm and implement effective oversight measures.

I. Investigation

On April 7, 2010, we notified then-Governor Charlie Crist and DJJ officials of our commencement of this investigation pursuant to Section 14141. On July 6-9, 2010 and May 17-19, 2011, we conducted on-site inspection tours with consultants in the fields of juvenile protection from harm and adolescent medical care. We interviewed staff members, youth, medical and mental care providers, teachers, and administrators. Before, during, and after our visit, we reviewed documents, including policies and procedures, incident reports, youth records, medical reports, unit logs, orientation material, staff training material, and use of force videos and accompanying reports. Consistent with our commitment to conduct our investigations in a transparent manner and to provide technical assistance where appropriate, we conducted exit conferences with NYFDC and DJJ officials, during which our consultants conveyed their preliminary observations and concerns.

We would like to note that the staff and administrators of NYFDC, including Superintendent Michael Cantrell, were helpful, courteous, and professional throughout our investigation. We would also like to express our appreciation to the DJJ for its cooperation throughout our investigation. We are hopeful that State and DJJ officials are committed to remedying the deficiencies identified in this Report on a system-wide basis as the problems identified at NYFDC continued due to the failure of the oversight system.

We find that several conditions and practices at NYFDC violated the constitutional rights of the youth confined to its care. Specifically, we find that

juveniles were subjected to excessive use of force by staff; that youth were subjected to lengthy and unnecessary isolation; that youth were deprived of necessary medical and mental health care, including adequate suicide prevention measures; that youth were subjected to punitive measures in violation of their due process rights, such as extensions of their confinement at the facility and, when both facilities were in use, punitive transfers to the more restrictive facility; that youth were denied rehabilitative services; and that youth were subjected to unsafe and unsanitary facility conditions. We also found problems particular to each of the facilities, including, at Dozier, staff subjecting youth to unwarranted, intrusive, and excessive frisk searches. As detailed below, the conditions we found resulted in youth suffering grievous harm. Although Dozier and JJOC are now shuttered, these problems persist due to the weaknesses in the State's oversight system and from a correspondent lack of training and supervision.

II. **Background**

Our investigation initially focused on Dozier and subsequently expanded to JJOC. During our July 2010 tour, the State revealed its plan to merge administration of Dozier with JJOC while maintaining separate facilities for the youth.² As explained further below, Dozier and JJOC were very different facilities in terms of restrictiveness level, the length of the youths' commitment to each facility, and the level of confinement appropriate for the category of youth in each facility. According to the State's merger plan, the facilities would be consolidated and renamed the North Florida Youth Development Center, with staff referring to Dozier as the "open campus" and JJOC as the "closed campus." The facilities shared staff, forms, processes, and procedures.³ In Fall 2010, the Dozier campus began to accept a new population of juveniles, including 15 children classified as "developmentally delayed."

By March 2011, however, Dozier started to transition all youths from its campus to other facilities. The majority of the youth were sent to JJOC and the youth in the developmental program were transferred to the Ockaloosa

² A similar merger had occurred for approximately two years ending in early 2009, when Dozier and JJOC operated a joint admission and orientation program. Bureau of Quality Assurance Program Review for Dozier Training School at 3 (December 2009) available at <http://www.djj.state.fl.us/QA/programreports/residential/dozier.pdf>. Under this program, both facilities had independent superintendents who reported to a "complex facility director." Id. Dozier youth attended admission and orientation programs at JJOC, stayed there for the period it required to "internalize the rules and exhibit appropriate behaviors," and then transferred to the Dozier campus. Id.

³ While our review was focused on Dozier, we received some documents and videos regarding JJOC youth. We also reviewed material involving Dozier youth who were transferred to JJOC.

Youth Development Center. On May 26, 2011, the DJJ announced the pending closure of both Dozier and JJOC citing budgetary limitations. The facilities were officially closed on June 30, 2011. The remaining residents were transferred to DJJ facilities throughout the system.

Prior to the eventual closure of Dozier, Dozier was a state operated “high risk” residential commitment facility.⁴ It housed juvenile males between the ages of 13 and 21 who were committed by the court. Dozier had space for 104 juveniles. Dozier was surrounded by a perimeter fence and had locking doors for each individual living unit, called “cottages.” Youth resided in several cottages within unlocked, single rooms. The facility, which opened 110 years ago, was located in rural Florida on 159 acres of property. The average length of stay for youth committed to Dozier was 9-12 months.

Dozier was located on the same grounds as JJOC, a maximum risk state operated facility for boys who were sentenced to serve a maximum of 18 months. JJOC was structured like a prison, with locked single-cells for the boys. JJOC was more secure and harsher than Dozier and was for “chronic offenders” who committed “offenses consisting of violent and other serious felony offenses.”⁵ The boys were confined to single living areas, referred to as “pods,” which were similar to a prison hall with individual cells with heavy metal doors along the corridor. The beds were made of concrete with a thin pad serving as a mattress. The building was surrounded by razor wire. The outside areas branching off of the main building were also surrounded by razor wire, including the areas designated for outdoor activities.

The relocation of Dozier youth to JJOC before the closure announcement led to immediate threats to the safety of the Dozier youth. In particular, there was an increase in uses of force by staff during the month of the transition. Compared to Dozier, youth at JJOC received less counseling and were

⁴ The DJJ has five restriction levels for placement of juveniles: (1) minimum-risk nonresidential, (2) low-risk residential, (3) moderate-risk residential, (4) high-risk residential, and (5) maximum-risk residential. Dozier is a high-risk residential facility, which includes facilities where juveniles are closely supervised in a “structured residential setting that provides 24-hour secure custody and care.” Florida Department of Juvenile Justice website, at <http://www.djj.state.fl.us/Residential/restrictiveness.html>. Juveniles in high-risk facilities have restricted community access, limited to “necessary off-site activities such as court appearances and health-related events.” Florida Department of Juvenile Justice website, at <http://www.djj.state.fl.us/Residential/restrictiveness.html>. In limited circumstances, with court approval, the resident may be allowed unsupervised home visits as part of the transition before being released from the facility. Id.

⁵ See Department of Juvenile Justice website at <http://www.djj.state.fl.us/Residential/restrictiveness.html>.

subjected to more restrictiveness, given the limited access to vocational education and recreational activities and less freedom of movement overall. One youth aptly observed that he felt his punishment was increased as a result of his transfer to JJOC.

Dozier's Superintendent, Michael Cantrell, who started on January 4, 2010, was the facility's seventh superintendent in nine years. Cantrell's predecessor resigned on December 17, 2009, after less than two years in the position. During his tenure, Cantrell made some positive changes at Dozier, such as terminating some staff who were engaged in abusive behavior and increasing the positive incentive system for youth. These positive steps were compromised when Dozier youth were transferred to JJOC.

Years ago, Dozier was the subject of a class action litigation regarding the conditions of confinement.⁶ The case was filed in 1983 against several State officials and agencies concerning conditions at some of the State's training schools and juvenile justice programs. With respect to Dozier, the plaintiffs alleged that youth were hogtied, shackled, and often held in solitary confinement. The case settled in 1987 with the parties entering into a consent decree. In 1995, the judge dismissed the consent decree against Dozier with prejudice -- over the plaintiffs' objections.⁷ Dozier has since been the subject of media reports suggesting that juveniles at the facility were subjected to significant abuse at the hands of staff.⁸ On February 25, 2011, the facility became the subject of another class action lawsuit alleging constitutional violations, including abusive and unsafe conditions of confinement.⁹

In part, as a result of the prior lawsuit and resulting legislative reforms, the DJJ has a very well-developed statewide system of written procedural protections in the form of written policies and procedures. While these policies and procedures are available to State juvenile facilities, including Dozier and JJOC, our findings show that the ethos behind these policies and procedures has not adequately translated into action. Indeed, at Dozier and JJOC, many of the policies were disregarded and many of the procedures were inadequately implemented. Harmful practices threatened the physical and mental well-

⁶ See Bobby M. v. Chiles, 907 F.Supp. 368, 369 (N.D. Fl. 1995). At the time, the facility was called the Arthur G. Dozier Training School.

⁷ See Bobby M., 907 F.Supp. at 369.

⁸ See Ben Montgomery & Waveney Ann Moore, 100 Years Later and Its Still Hell, St. Petersburg Times, Oct. 11, 2009 at 1A. See Ben Montgomery, Files Verify Boys' Abuse, St. Petersburg Times, Sept. 24, 2009 at 1A; see also Jim Schoettler, Summaries Unveil Recent Abuse Cases at Dozier, The Florida Times-Union, Sept. 25, 2009 at B-3. Allegations of past abuses have also been discussed in non-fiction books such as The White House Boys: An American Tragedy by Roger Dean Kiser (2008).

⁹ See J.B. v. Walters, et al., 4:11-cv-00083-RH (N.D. Fl. 2011).

being of the youth committed to these facilities. These harms were clearly evident in a number of areas at NYFDC and yet the DJJ's oversight system failed to adequately address the safety of the youth. Despite its policies and procedures, the State hired abusive staff at NYFDC, failed to provide the requisite training to staff to ensure that they protected the youth in their care, failed to ensure that the requisite supervision was in place to prevent and detect abuses, and failed to have an effective accountability process. We therefore believe that the harm suffered by juveniles confined at Dozier and JJOC is not limited to those facilities. Accordingly, we are sharing these findings with the State despite the closure of these facilities.

III. Findings

We find that the State failed to adequately protect youth confined to Dozier and JJOC from harm and threat of harm by staff, other youth, and self-harm. The State's failure to ensure the adequate implementation of its policies caused unconstitutional conditions of confinement. It is imperative that the State ensure implementation of its policies and reform of its practices to bring its juvenile detention facilities into compliance with constitutional standards.

Detained youth are protected by the Fourteenth Amendment and have a substantive due process right to reasonably safe conditions of confinement and freedom from unreasonable bodily restraints. See Youngberg v. Romeo, 457 U.S. 307, 315-16 (1982) (recognizing that a person with developmental disabilities in state custody has substantive due process rights under the Fourteenth Amendment); Bell v. Wolfish, 441 U.S. 520 (1979) (applying the Fourteenth Amendment standard to facility for adult pre-trial detainees); H.C. v. Jarrard, 786 F.2d 1080, 1085 (11th Cir. 1986)(holding that conditions of pretrial juvenile detainees "affect liberty interests protected by the Fourteenth Amendment."). The Fourteenth Amendment, rather than the Eighth Amendment, applies to youth confined to juvenile facilities because adjudicated youth are held for rehabilitation, not punishment.¹⁰ Conditions of confinement claims may be based not only upon existing physical harm to youth, but also on conditions that threaten to cause future harm to confined youth. Helling v. McKinney, 509 U.S. 25, 33 (1993) (stating "[i]t would be odd to deny [relief to

¹⁰ In Ingraham v. Wright, the Supreme Court refused to apply the Eighth Amendment deliberative indifference standard in a non-criminal context. 430 U.S. 651, 669 n.37 (1977) ("Eighth Amendment scrutiny is appropriate only after the State has complied with the constitutional guarantees traditionally associated with criminal prosecutions."). Moreover, in Bell, 441 U.S. 520, the Court held that the Due Process Clause of the Fourteenth Amendment was the appropriate basis to determine the rights of adults detained by a state, but not yet convicted of any crime. See also H.C. v. Jarrard, 786 F.2d at 1085. At minimum, youth should be accorded the same protections.

detainees] who plainly proved an unsafe, life-threatening condition in their [facility] on the ground that nothing yet had happened to them.”).

To determine whether the Fourteenth Amendment was violated, a balancing test must be applied: “[I]t is necessary to balance ‘the liberty of the individual’ and ‘the demands of an organized society.’” Youngberg, 457 U.S. at 320 (citing Poe v. Ullman, 367 U.S. 497, 542 (1961) (Harlan, J., dissenting)). The Youngberg Court went on to hold that “[i]f there is to be any uniformity in protecting these interests, this balancing cannot be left to the unguided discretion of a judge or jury.” Id. at 321. Instead, the Court held that there was a constitutional violation if the detaining official substantially departed from generally accepted professional standards, and that departure endangers youth in their care. See id. at 321.

1. Excessive Uses of Force

Juveniles have a constitutional right to be free from physical abuse by staff and from assaults inflicted by other juveniles. Youngberg, 457 U.S. at 315-16 (“the right to personal security constitutes a ‘historic liberty interest’ protected substantively by the Due Process Clause”); Jarrard, 786 F.2d at 1085 (juvenile’s due process rights violated when detention officer slammed him against a wall and a metal bunk in an isolation cell); Bozeman v. Orum, 422 F.3d 1265 (11th Cir. 2005)(force used against 17-year-old pre-trial detainee was excessive where the detention officers continued to use force, shackling him and sitting on him, after he was subdued). Generally accepted juvenile justice standards require that juveniles be provided with a safe environment and that force be used only as a last resort. Absent exigent circumstances, lesser forms of intervention, including verbal de-escalation methods, should be used or considered prior to more serious and forceful interventions.

We learned that despite policies requiring that force be a last resort, staff subjected youth to force as a first resort. This violation occurred even though DJJ provides training that emphasizes a preference for verbal intervention and de-escalation of conflict. The DJJ authorizes facilities to train staff on use of the “Protective Action Response” (“PAR”) measures – which include both verbal and physical intervention – to address youth behavior. PAR includes three different response levels: level 1 consists of verbal intervention; level 2 includes touch and countermove techniques as well as takedown methods;¹¹ and level 3 involves the use of mechanical restraints. The DJJ only authorizes

¹¹ According to the training director, the primary PAR technique is a “straight-arm” take down to the ground technique. If a child is already on the ground, a PAR technique would only be required if the youth’s arms are blocked (underneath) by his body; this technique involves pulling the child’s arms from under his body. Staff are prohibited from implementing force involving punches, strikes, kicks, or pressure points.

physical intervention where “a clear and identifiable risk to safety and security” is present.¹² Further, DJJ rules require that “counseling, verbal intervention, and de-escalation techniques are used prior to physical intervention.”¹³

Despite these rules and the attempts of facility leadership to implement even stricter rules, such as a zero tolerance rule implemented by Cantrell at Dozier, the use of excessive force against youth was a persistent problem. For example, at Dozier, we learned that staff used force as a first resort against youth engaged in non-violent and non-threatening behavior. Staff took youth to the ground using the dangerous face down prone restraint technique. Staff engaged in impermissible uses of force such as choking. And, finally, staff used force when a youth was already subdued, including use of mechanical restraints. These practices occurred even more frequently at JJOC. In fact, the 2011 JJOC rate of physical restraint events was nearly seven times larger and more than five times greater than the Performance-based Standards for Youth Correction and Detention Facilities’ Field Average (“PbS Field Average”).¹⁴ Even more troubling, the JJOC rate of takedowns alone was over 2.5 times greater than the rate of *all* physical restraint events in the PbS Field Average.

We also found that many uses of force were not appropriately documented and were often conducted outside the view of facility cameras. Inadequate documentation and recording of use of force incidents leads us to question whether uses of force at Dozier and JJOC were even *higher* than the data suggests.

a. Unnecessary Uses of Force

The needless imposition of force on a juvenile is a violation of his constitutional rights. Jarrard, 786 F.2d at 1085. Moreover, continued use of force is excessive where the juvenile is already subdued. Bozeman, 422 F.3d at 1265. Youth confined at NYFDC were subjected to excessive force. While a number of staff were terminated or placed on “no contact” status as a result of excessive uses of force, oftentimes improper uses of force were deemed

¹² DJJ Administrative Rules, Protective Action Response Policy, 63H-1.003. This rule is copied on the facility level as well. For example, Dozier was supposed to follow a similar rule. See Facility Operating Procedures (“FOP”), FOP 208 (March 4, 2010).

¹³ Id.

¹⁴ The Performance-based Standards for Youth Correction and Detention Facilities was developed in 1995 by DOJ, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention (“OJJDP”) to assess conditions of juvenile confinement. PbS establishes goals and standards for facilities. Participating facilities collect information in an effort to identify problems and improve conditions. See Council of Juvenile Correctional Administrators, available at <http://cjca.net/initiatives/performance-based-standards-pbs>.

appropriate by reviewers, who generally were Juvenile Justice Residential Officer (“RO”) supervisor or training coordinators. The following incidents, which occurred at NYFDC, are illustrative of the pattern or practice of excessive force staff routinely used against youth.

- AA¹⁵ complained that he was choked during an altercation with a RO on June 28, 2010. A video of the encounter shows that after a brief verbal exchange with the RO, the RO violently pushed AA onto his back on what appears to be a mattress. AA was pushed mostly out of the view of the camera, but his feet were still within view. The video shows that the RO remained on top of AA for about 10 seconds before both were out of view of the camera. AA reportedly had scratches on his neck following the incident and is seen on the video touching his neck once he was within view of the camera again. The facility found the use of force to be appropriate even though the youth presented no apparent danger before the RO used force against him.
- On August 20, 2010, BB asserted that a RO injured him during an unnecessary takedown. A video of the incident shows the RO pushing BB to the ground without any apparent provocation. The youth had been seated on a table and was fiddling with what appeared to be a hand towel. According to the RO’s incident report, the youth had tried to harm himself with the towel and refused to release the item. Although this rationale is difficult to discern from the video, the facility found that force was appropriately used. While use of force may be appropriate to prevent imminent bodily harm, that does not appear to be the basis for use of force in this instance.
- On September 10, 2010, a RO provoked CC into an argument and then slammed CC into furniture and onto the ground. Before the assault, the RO approached CC as he leaned against a desk in the common room as other youth milled about the room. CC appeared to be somewhat withdrawn, but was not engaged in violent or disruptive behavior. The RO continued to address CC and, after about a minute, shook CC’s arm. CC did not react to the RO, keeping his head down. The RO held on to CC’s arm and then attempted to force the youth’s left arm behind his back. At this point, CC moved to escape the arm lock. The RO followed CC and argued with him, moving his chest against the youth’s chest and shadowing him. Even though CC moved slowly away and seemed

¹⁵ We will use pseudonyms throughout this Report to protect the identities of the youth involved in various incidents.

to be trying to avoid further confrontation, the RO continued to shadow CC. CC was clearly being taunted and aggravated. CC responded by arguing with the RO and they ended up bumping chests. The RO then pushed CC onto an armchair, sliding both the youth and the armchair across the room and into a wall, causing CC to fall to the ground. While CC was still on the ground, with his back on the floor, the RO hovered over him and appeared to strike and choke the youth. The incident was reviewed and found to be an improper use of force.¹⁶

- In another incident involving CC, the use of force was found to be appropriate after the RO took the youth down to the ground. According to the incident report, the RO verbally directed CC to remain in bounds but the youth kept walking out of bounds. In the video, CC made no aggressive motions and simply appeared to be disobedient. The RO then physically forced CC to the ground in order to get him to comply with the directions. Once he was forced to the ground, CC started resisting. The RO reacted by forcefully grabbing the youth's arm and dangerously placing his body weight on the youth to keep him still. Eventually, other ROs approached to assist the initial RO. This incident developed when the RO unlawfully used force as a response to a youth who was not violent, did not appear to be hurting himself, and did not appear to be threatening towards other staff or youth.
- At Dozier, several boys reported witnessing a RO choke another youth, DD, until foam came out of his mouth. Choking is an unlawful use of force.

These examples demonstrate that despite DJJ's appropriate directives to only use force when there is "a clear and identifiable risk to safety and security," force was often used a first resort and in circumstances where no risk to safety and security was present.

b. Dangerous Use of Restraints

The excessive and unnecessary use of prone restraints places youth at great risk for harm. The practice of face down prone restraint is highly problematic and even more dangerous when force is applied to the prone youth. Evidence at NYFDC suggests that staff at Florida's juvenile facilities are not properly trained on the use of this technique. First, incident reports, complaints of youth, and videos indicate that not all ROs are implementing this procedure in a manner that ensures youth safety. Indeed, we reviewed

¹⁶ There is a reference in the review to the RO being recommended for discipline, but the final outcome is unclear.

incidents where staff put their body weight on a child in prone restraint for several minutes – which can cause suffocation.¹⁷ Next, we found that many ROs had not completed the required training – including refresher training – compromising the safety of youth upon whom this restraint method is performed. For example, over 75% of staff placed on no-contact-with-youth status during our first on-site tour, due to improper use of force allegations, had not completed or updated their basic training requirements at the time of their placement on no-contact status. Finally, in many cases we reviewed, the use of prone restraints was excessive in light of the non-dangerous conduct that led to use of prone restraints by staff. For example:

- GG was tackled to the ground shortly after the incident escalated to use of force. Two ROs kept him prone on the ground for more than five minutes. For most of that time, at least one of the ROs appeared to be pressing his body weight onto the youth.
- The second incident with CC (described above) also demonstrates improper use of prone restraints. In that incident, CC was placed in prone restraints for the non-dangerous conduct of disobeying an order. Once on the ground, the staff also dangerously put their body weight onto CC to keep him still.

Staff also unlawfully used mechanical restraints as a first response to youth who did not respond to verbal commands. While DJJ rules allow for the use of mechanical restraints in limited situations – such as where youth are engaged in “aggravated resistance” – the ROs at NYFDC routinely placed metal handcuffs and leg-cuffs on youth who are merely verbally resistant and did not pose a risk to themselves or others in the facility. This is unconstitutional. Jarrard, 786 F.2d at 1086 (needless application of force, including mechanical restraints, where juvenile detainee was “merely giggling” and protesting the treatment of another detainee unconstitutional). For example:

- JJ was placed in mechanical restraints for failing to obey verbal orders. While a video recording shows that he was in fact placed in restraints for failing to obey a RO’s command, the incident report omits any reference to mechanical restraints. In another incident involving the same youth, JJ was placed in metal handcuffs and leg cuffs because he spat on a RO. In another episode, ROs placed JJ in mechanical restraints after he refused to return to the

¹⁷ In a 50-State survey of mental health facilities conducted by the Hartford Courant, 142 deaths occurred between 1988 and 1999 during or shortly after the application of restraints or seclusion. Of the 142 deaths, “[t]wenty-three people died after being restrained in face-down floor holds.” Eric M. Weiss, Hundreds of the Nation’s Most Vulnerable Have Been Killed by the System Intended to Care for Them, Hartford Courant, October 11, 1998, A1.

common room. None of these instances rise to the level of “aggravated resistance,” and thus the use of mechanical restraints in these circumstances constitute excessive force.

- Staff placed another youth, RR, in mechanical restraints for tying a sweater around his neck in a gesture of suicidal ideation. Three staff members used a PAR technique to take the youth to the floor. After the youth was held in a PAR restraint, facedown on the floor for 48 minutes, he was placed in mechanical restraints for an additional three hours and seventeen minutes, totaling four hours and five minutes of restricted movement.

Despite the presence of good written policies, the youth were subjected to a pattern or practice of unconstitutional uses of force as is evidenced in the above accounts. In many instances, youth were subjected to uses of force in circumstances that required only verbal intervention, and, in other instances, subjected to altogether inappropriate force, including prone restraints and unlawful use of mechanical restraints. Such conduct violates the youths’ constitutional right to adequate protection from harm, reasonable safety, and freedom from undue restraint. Youngberg, 457 U.S. at 315-16.

c. Dangerous Off-Camera Assaults

Youth at Dozier were often subjected to staff violence in facility regions outside of the viewing range of surveillance cameras. While the administrative staff made efforts to address force incidents captured on video, they were not as vigilant when there was no on-camera episode to corroborate a youth’s abuse complaint. The facility was replete with off-camera areas, including the laundry room in each cottage, the area of the hallways leading to the showers, the immediate area outside of the cottages, and numerous outdoor areas. Many of the youth complained that ROs often directed them to off-camera areas. Youth reported that their safety was in the greatest jeopardy – primarily from staff and occasionally other youth – in these off-camera areas. These areas were not only dangerous to the youth; they also made adequate internal and external reviews of abuse complaints next to impossible. In a complaint to the Department of Child and Family Services, for example, HH reported that staff allowed other youth to engage in fights off-camera in the laundry room (referred to by staff and youth as the “sheet locker”). The report could not be verified because there was no video of the incident and no documentation of an assault. Other examples include the following:

- Several youth reported that ROs often used force against them “off-camera.” One youth, FF, referred to the ROs as being “dirty” for taking kids out of the view of the cameras and hurting them. According to FF, “You’ll learn fast. Just don’t go off camera and get PAR’d.” FF was assaulted off-camera, but refused to identify the responsible RO.

- A complaint to DJJ’s Central Communications Center by II, that he was slammed against a bathroom wall by staff – could not be substantiated because the alleged assault took place off-camera and no other youth witnessed the incident.
- Youth also reported being assaulted on their way to the isolation unit. There was a camera attached to the building housing the isolation unit, covering several feet immediately in front of the building. Most of the distance between the cottages and this building, however, was beyond the camera’s range and hidden by a thicket of trees. Many youth noted that this area was a major source of danger to their safety.

Dozier youth were also at risk from youth-on-youth assaults due to the design of some of the cottage rooms. Each cottage had two rooms with a shared wall that stopped short between two to three feet from the ceiling, leaving enough space for youth in these rooms to move between the two rooms and the hallway. During our tour, we observed that youth had stacked chairs on the desks in these rooms in order to climb over the short walls. This created a risk of harm in several respects. Youth could climb over these short walls in order to engage in a fight, engage in sexual relations, or confront a RO in the hallway.

2. Poor Documentation and Data Collection Efforts

The pattern or practice of excessive force being used on youth at NYFDC was obfuscated by its poor documentation and data collection efforts, even though the facilities had the capacity to conduct sophisticated data analysis. Many incident reports did not provide a complete account of the incidents and were therefore not useful for determining specifically what happened, in preventing future misconduct, and protecting youth from harm. For example, our review of 138 Dozier use of force reports from April 2010 identified problems such as (1) reports that were so poorly written that it was difficult to determine what behaviors were being reported, (2) reports lacking in details to establish the appropriateness of the use of force, and (3) underreporting of problematic responses to youth behavior. As a result of these reporting deficiencies, Dozier’s rates for physical restraints, youth-on-youth fights, confinements, and grievances all appeared to be lower than the national averages captured in the PbS Field Average. We do not have confidence in these rates, however, due to the apparent inadequacy of the documentation process. We also found similar documentation problems at JJOC and are concerned that staff may have underreported incident there too.

As noted above, the documentation problems were manifested in various ways, including cursory explanations of the force episodes that omitted key information that could assist a reviewer in determining whether force was appropriately used. The reports also failed to describe the injuries sustained

by youth as a result of physical interventions. The following examples provide a sampling of the problems.

- One youth, KK, reported to the DJJ's complaint line that a RO pushed him, called him a derogatory name, and threatened him. Neither the accused RO nor the other RO on duty completed a report about the incident. The incident was substantiated by the DJJ investigator only because it had been captured on video and other youth verified the account.
- In another episode involving DD, the incident report noted that he was subjected to a takedown maneuver because he was disruptive and failed to obey a RO's directives. However, the accompanying video recording only shows the youth on the ground. Nothing is shown of the events preceding the takedown, making it difficult to discern whether the use of force was appropriate.
- In one incident, ROs placed a youth in mechanical restraints for failing to obey verbal orders, but the incident report excluded any mention of the mechanical restraints. A video recording showed that the youth was in fact placed in restraints for failing to obey a RO's command. In two other incidents where ROs placed the same youth in mechanical restraints, the reports failed to note the length of time he remained in the restraints.

The grievance system also suffered from poor documentation of incidents. Youth at Dozier were able to submit grievances; however, contrary to the facility's procedures, they were not informed of the outcomes.¹⁸ While the grievances included reports of staff misbehaviors requiring further investigation, investigative findings were generally non-existent. This lack of formal written findings also extended to outside reviews of youth complaints. Because of the limited investigation and insufficient documentation, youth complaints of abuse were often not substantiated. This problem existed to an even greater degree at JJOC, where the rate of grievances was 98% less than the 2010 Dozier rate and one tenth of the PbS Field Average. The infrequent use of the grievance system at JJOC is troubling and indicates that youth were either unaware of the grievance system, unable to access the grievance system, or as several youths attested, had no confidence in the grievance system.

The documentation problem also extended to the medical care NYFDC youth received. Oftentimes, the ROs did not call medical or mental health staff to treat youth who may have been injured as a result of uses of force. For

¹⁸ FOP 206 (January 19, 2010). Under FOP 206, youth grievances are to be investigated and decided within 48 hours. The youth is supposedly provided with an opportunity to appeal the decision.

example, a review of the incident reports indicated that 90% of the reports did not include medical or mental health findings. When the medical staff actually did treat youth who had been subjected to force, they failed to record the physical condition of the child. For example, medical staff did not photograph youth following a takedown or other physical intervention. They also did not diagram the youth's injuries nor did medical staff follow-up with youth who had been physically restrained.

Improved record keeping would enable the State's juvenile facilities to be more aware of persistent issues, which in turn would assist the facilities' efforts at improving the conditions of confinement.

3. Unlawful Uses Of Isolation

The State may not subject confined juveniles to undue restraint. See Youngberg, 457 U.S. at 315-16. When the State subjects a juvenile to certain disciplinary procedures, such as extended isolation, the State must provide the juvenile with an opportunity to present evidence in his or her defense. Jarrard, 786 F.2d at 1086 (affirming award of compensatory damages for juvenile pre-trial detainee placed in isolation for seven days after laughing and protesting when another juvenile was placed in isolation); Gary H. v. Hegstrom, 831 F.2d 1430, 1433 (9th Cir. 1987)(upholding district court's requirement that a juvenile facility hold "due process hearings prior to confinement in excess of 24 hours"); Milonas v. Williams, 691 F.2d 931 (10th Cir. 1982)(affirming a permanent injunction on the use of isolation rooms by private school to which adjudicated juveniles were confined). The practice of isolation is disfavored for juveniles as it generally serves a punitive purpose. See e.g. Santana v. Collazo, 714 F.2d 1172, 1181 (1st Cir. 1983) (recognizing expert testimony that "isolation for longer than a few hours serves no legitimate therapeutic or disciplinary purpose and is unnecessary to prevent harm unless a juvenile is severely emotionally disturbed."). Moreover, the use of isolation is highly disfavored by experts in juvenile protection from harm. For example, the Performance-based Standards issued by the Council on Juvenile Correctional Administrators indicate that isolation should be avoided and only used for a brief period where it is required. PbS Standards (April 2010). Isolation should not be used as a matter of course and should be used only as a last resort, should be carefully reviewed, and used only for a limited duration. See American Bar Association, Juvenile Corrections Standards, §7.11 (1980). The State's use of isolation in non-emergency circumstances and for long periods of time – i.e. as punishment – is a violation of due process. R.G. v. Koller, 415 F.Supp.2d 1129, 1155 (D. HI. 2006) (finding that juvenile conditions expert testimony "uniformly indicates that long-term segregation or isolation of youth is inherently punitive" and that the "use of isolation for juveniles, except in extreme circumstances, is a violation of Due Process.").

The State subjected youth to unconstitutional disciplinary confinement by (1) failing to provide youth placed in confinement with adequate due process, (2) confining youth for undue and excessively long periods of time, (3) confining youth as a form of punishment for minor infractions, and (4) depriving confined youth of necessary rehabilitative services.

Youth at Dozier were subjected to two forms of confinement. First, a youth could be placed on “controlled observation” (“CO”) for a two hour “cool down” period. According to FOP 210, the CO is “intended to help staff quickly regain control and order in the program to divert serious injuries, security breaches, or major property destruction.” Second, youth could be taken to the Behavioral Management Unit (“BMU”) for 72 hours to 21 days, depending on the recommendation of two members of his “treatment team.”¹⁹ According to FOP 211, the BMU should be used “only when a youth’s behavior significantly disrupts the program’s residential community, endangers the safety of staff and other youth, or threatens major destruction of property, and when used, youth are protected from self-harm.” The actual practice at Dozier, however, was to send youth to the BMU or CO for minor infractions. Use of the BMU was discontinued during the transition period before the official closure of Dozier. At JJOC, youth were placed on confinement in the Intensive Supervision Unit (ISU), which was designed as a secure unit with four rooms that were used for a short-term time-out or longer-term isolation. Despite the change in name and location, youth continued to be placed in isolation for minor infractions, and this undue restraint was unconstitutional.

The isolation units on both the Dozier side and the JJOC side of NYFDC were particularly harsh environments. At Dozier, while using different names to describe the units (CO and BMU), the only real difference in the environment was the amount of time a youth was required to stay in confinement. The CO/BMU consisted of six single cells measuring approximately 9.8 feet by 5.5 feet, with locking doors, a concrete slab serving as a bed, bars on the windows, and a clear hard plastic window over the bars. At bedtime, the youths received a thin mattress to cover the cement slab. The bathroom was in an area separate from the cells. The CO/BMU was located in a building that was a distance from the residential cottages, over 200 yards through a wooded area.

¹⁹ A note on nomenclature: Dozier uses some terms in ways that do not actually reflect what the terms more commonly denote. For example, the term “treatment team” is used by staff to describe any staff person who interacts with the child, including direct care staff such as ROs and administrative, medical, education, or recreation staff. “Treatment teams” may or may not include mental health staff. In the context of making a disciplinary confinement decision, two members of a youth’s “treatment team” may include any two ROs, or a combination of a RO and another staff member (administrative, case worker, teaching, medical, or mental health). In other words, there is no required mental health component to the disciplinary confinement decision.

Youth were walked to the CO/BMU from the cottages or they were transported there in a van. The ISU in JJOC was located in the same building as the regular residences, but in a separate pod. There were four rooms on the pod similarly furnished with a concrete slab serving as a bed. The rooms in ISU did not have windows.

Our review of incident reports indicates that isolation was oftentimes used as a punitive measure for minor rule violations. For example, Dozier youth were sent to the CO and BMU for “excessive horseplay,” name calling, “talking to other youth,” “causing a disruption,” and “being uncooperative.” JJOC youth were sent to the ISU for similarly minor infractions, including refusing verbal commands, being argumentative, running “off-bounds” around a fenced-in basketball court, and horseplay. While DJJ’s rules appropriately refer to disciplinary confinement as “the most restrictive method of behavioral management,” youth were routinely confined in the CO/BMU/ISU for what can only be described as nuisance behavior. Additionally, in committing youth to the disciplinary confinement, staff did not provide youth with an opportunity to challenge the commitment decision -- in violation of their rights. Gary H., 831 F.2d at 1433. Instead, youth were only advised of the “maladaptive” behavior leading to their commitment and the goals that they must reach in order to be released. The length of a youth’s confinement to the isolation units was also difficult to discern – the rules only provide for a review every 72 hours after 14 days of continuous confinement and approval by the Superintendent (or a designee), but do not prohibit unlimited extensions of confinement. In one particularly stark example, SS was repeatedly placed in the ISU for approximately two weeks. He would be released for several hours after a few days and then returned to the ISU.

The isolation units did not serve any rehabilitative purpose. This is most apparent in the limited to non-existent role of the mental health staff in the determinations to send youth to disciplinary confinement. Specifically, the mental health staff did not have veto power to prevent a child from being sent to the CO or to request that a child be released from disciplinary confinement. As such, suicidal youth were sent to isolation, although the facility rules prohibit confinement of such youth. This practice is very dangerous as “[i]solation increases the sense of alienation and further removes the individual from proper staff supervision.” Lindsay M. Hayes, Suicide Prevention in Juvenile Facilities, 7(1) J. Office of Juvenile Justice and Delinquency Prevention, 29 (2000). Additionally, youth confined in the isolation units did not consistently receive required services, such as education materials, regular mental health evaluations, or daily large muscle exercise. In sum, the confinement units only served as punishment to uncooperative youth and a warning to others. Thus, this practice violated the youths’ constitutional rights.

4. Deliberate Indifference To Youth At Risk Of Self-Injurious And Suicidal Behaviors

The State must provide juveniles held in its facilities with adequate medical treatment. Youngberg, 457 U.S. at 323-24 & n.30; Jarrard, 786 F.2d at 1086 (denial of medical care to juvenile for three days after injury caused by the guard found unconstitutional); Bozeman, 422 F.3d 1265 (recognizing deliberate indifference where prison officials ignore inmate's known serious medical condition). This requirement to provide adequate medical care includes a requirement to provide adequate mental health care. Cook v. Sheriff of Monroe Cty., Florida, 402 F.3d 1092, 1115 (11th Cir. 2005). The due process right to receive medical treatment "encompasses a right to psychiatric and mental health care, and a right to be protected from self-inflicted injuries, including suicide." Cook, 402 F.3d at 1115 (quoting Belcher v. City of Foley, 30 F.3d 1390 (11th Cir. 1994)); see also Snow v. City of Citronelle, 420 F.3d 1262 (11th Cir. 2005)(same). As the Eleventh Circuit has recognized, actions that violate a prisoner's Eighth Amendment rights, such as those actions that would be considered deliberately indifferent to a prisoner's mental health needs, also violate the greater due process Fourteenth Amendment rights of those subjected to the state's custody through a non-criminal process. Dolhite v. Maughon, 74 F.3d 1027, 1041 (11th Cir. 1996). An official may be found deliberately indifferent where that official deliberately disregards a "strong likelihood" that a detainee will engage in self-injurious behavior. Cook, 402 F.3d at 1115; Snow, 420 F.3d at 1268.

The State subjected detained youth at NYFDC who suffered from serious mental health problems to deliberately indifferent treatment, heightening the risks of harm for suicidal youth. While no juveniles at NYFDC completed a suicide to our knowledge, the lack of a death does not minimize the serious risk for youth or the unlawful state of mental health care at the facilities. Helling, 509 U.S. at 33. The rate²⁰ of suicidal behaviors by Dozier youth was disproportionately high when compared with the PbS field average. The Dozier rate of 0.262 behaviors per 100 bed days was almost five times higher than the PbS field average of 0.057 behaviors per 100 bed days. These suicidal behaviors included suicidal ideation, suicidal gestures, and self-injurious behaviors. NYFDC youth were at risk in several respects: (1) the facility did not provide adequate mental health screening; (2) staff did not treat suicidal youth with the appropriate level of seriousness; (3) staff placed suicidal youth at further risk by putting them in isolation, transferring them to JJOC, or

²⁰ As with the incident reports and data on violent incidents discussed above, we do not have confidence in the accuracy of Dozier's reported accounts of youth suicidal behaviors. Dozier staff do not adequately document incidents that may include youth's self-injurious behaviors or threats. As such, the numbers of such incidents may be higher than we were able to discern.

placing them in physical restraints without consideration for their mental state; and (4) the facility had numerous structural elements that presented a danger to suicidal youth.

The initial screening of Dozier youth for mental health issues did not adequately identify the youth's psychological condition or potential susceptibility to suicidal behaviors. This deficiency was illustrated by the large number of youth diagnosed with the same, unspecified, disorder. Ninety youth were "diagnosed" on the facility's April 2010 Treatment Services Report. Eighty-nine of those youth were diagnosed as having "conduct disorder" without any modifiers as to their particular diagnoses.²¹ The extraordinarily high rate of this diagnosis, particularly in a facility addressing delinquent behaviors, makes the accuracy of the diagnosis and the methodologies of diagnoses highly questionable. And because the treatment programs established for Dozier youth are based on these unspecified diagnoses, youth were not receiving appropriate mental health care.

Direct care staff's laissez faire attitude toward suicidal youth also jeopardized their safety. A number of ROs and supervisors were dismissive of suicidal threats by youth as "attention seeking" and manipulative attempts to frustrate staff. Although one youth admitted that he claimed to be suicidal so that he could get more staff attention, such isolated conduct should not generate a sense of complacency among staff when a potentially serious situation could exist. Complacency is particularly troubling because direct care staff intervention, knowledge of suicidal risk factors, and attention to suicidal youth are critical components to suicide prevention. Hayes, Suicide Prevention in Juvenile Facilities, 7(1) J. Office of Juvenile Justice and Delinquency Prevention, 27-29 (2000). According to another study of youth suicide in juvenile facilities, approximately half of the suicides occurred during the evening hours when direct care staff are likely the only staff onsite.²² Lindsey Hayes, Juvenile Suicide in Confinement: A National Survey, National Center on Institutions and Alternatives, 25-26 (February 2004). Direct care staff investment in suicide prevention is therefore imperative.

This staff complacency further heightened the dangers to suicidal youth as evidenced by the staff's willingness to confine suicidal youth to isolation and

²¹ The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, (DSM IV 2000), defines conduct disorder as a "repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more)" criteria including aggression to people and animals, destruction of property, deceitfulness or theft, and violations of rules (including truancy and violations of parental curfews).

²² The study of 110 suicides between 1995 and 1999 found that 50.6% of suicides occurred during the period from 6:01 p.m. to midnight.

more restrictive environments without regard to their mental well-being. In a number of instances, we learned that youth who had made suicidal gestures or threats were placed in the BMU. As described above, the BMU was an oppressive environment that could aggravate the risk of suicide. Additionally, each of the cells had anchor points by the doors that could be used by a youth to attempt hanging.

Finally, many of the rooms and facilities at Dozier were not suicide resistant. The danger was heightened by the fact that the staff-to-youth ratio of 1:8 was often compromised, leaving the youth alone for long periods without supervision. Youth intent on hurting themselves at Dozier had access to anchoring points on bed frames, air vent grates in their rooms, handrails in the bathrooms, sprinkler heads in the shower stalls, and even some of the doors in the housing areas. These protruding points present serious risks to youth. Notably, many of the doors had small windows, allowing only a partial view of the rooms; this increased the risk that a staff person would not know when a child was attempting suicide behind the closed door. At JJOC, the rooms were less dangerous, but we found chairs in the bathroom areas that could be easily used to reach anchoring points. In the above mentioned national survey of youth suicide in detention, 98.7 percent of suicides were by hanging. The suicide victims used several types of anchoring devices, including door hinges or knobs (20.5%), air vents (19.2%), bed frames (19.2%), window frames (14.1%), and shower sprinkler heads (7.6%). Hayes, Juvenile Suicide in Confinement: A National Survey, National Center on Institutions and Alternatives, 27. The living quarters in NYFDC, which included most of these anchoring devices, posed a serious risk of harm to youth.

5. Disciplinary And Punitive Measures In Violation Of Youth's Due Process Rights

Confined youth have a due process right against restrictions that constitute punishment. Bell, 441 U.S. at 535 (recognizing that conditions and restrictions imposed upon pre-trial detainees that amount to punishment violate the Due Process clause); Youngberg, 457 U.S. at 315-16 (right to freedom from undue bodily restraint is a core interest protected by the Due Process Clause); Jarrard, 786 F.2d at 1085 (“[T]he due process clause forbids punishment of pretrial detainees.”). Juveniles are entitled to due process when their liberty interests are at stake. Jarrard, 786 F.2d at 1085; Gary H., 831 F.2d at 1433; Milonas, 691 F.2d at 942; Mary and Crystal v. Ramsden, 635 F.2d 590 (7th Cir. 1980) (juveniles have a right to present evidence on their own behalf for hearings resulting in disciplinary isolation). Dozier officials subjected the youth in their care to two practices that served no rehabilitative purpose and were punitive: first, officials increased the youths’ time in confinement for a period up to 120 days, and, second, officials transferred youth to JJOC, a facility designed for “maximum-risk” youth. These practices functioned as punishment and violated the youths’ constitutional right to

freedom from undue restraints. Both measures were levied against so-called problematic youth as a deterrent against acting out. Neither measure had a rehabilitative function or required the provision of necessary treatment. In addition, transfers were made recklessly where, for example, a youth who had been propositioned for oral sex by another youth was transferred to JJOC within two months of his tormentor's transfer to JJOC. Both practices were in contravention of the youths' due process rights, posing an undue restriction on their liberty without due process and without regard for their safety. Bell, 441 U.S. at 535; Youngberg, 457 U.S. at 315-16. Moreover, the measures were contrary to the requisite rehabilitative purpose of the juvenile system.

First, the measures posed an undue restriction on the liberty of Dozier youth.²³ The youth who received extensions were subjected to prolonged confinement beyond their release dates. During a sample one month period, for example, 15 youth received extended confinement. Most of the youth received four months of additional time to their detention at Dozier. Additionally, during our July 2010 tour, we learned that approximately 20 youth were subjected to JJOC transfers. Four additional youth were transferred in the month following the tour.

The measures were in contravention of youths' right to due process and access to the juvenile court. First, Dozier's administrators did not institute sufficient safeguards to ensure the fairness of these measures. The extension policy was ostensibly applied only to youth deemed aggressors in fights. A review of the incident reports, however, indicated that non-aggressors received additional time. One report, involving MM, showed him to be defending himself; he still received 60 days of additional confinement. On other occasions, the facility did not determine which youth was the aggressor and just extended both detentions. For example, a report of an incident between LL and NN noted that both were fighting, but does not identify which youth started the fight. Both LL and NN received additional confinement time. A similarly vague report of an incident between PP and QQ resulted in both boys

²³ For youth with disabilities, both practices – prolonged detention and transfers to a more secure facility – may have run afoul of Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132, and its governing regulations which prohibit “unjustified institutional isolation of persons with disabilities.” Olmstead v. L.C., 527 U.S. 581, 600 (1999). Under Title II, “no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.” Dozier youth with disabilities – such as youth with mental health challenges – face unjustified prolonged and extended detention due to their failure to progress through the program, in part, because they have not received the appropriate treatment. Transfer to a more secure facility may also be unlawful where the youth's behavior is connected to a disability for which treatment is required.

receiving four months of additional time. Regarding the JJOC transfers, it was absolutely unclear what behaviors would lead to a transfer or how a youth could avoid being transferred. Our review of the incident reports for some of the transferred youth suggests that many were being transferred for minor repeated nuisance issues or because they required more attention for reasons ranging from being disruptive to suicidal threats.

The arbitrary application of these punitive measures was compounded by the fact that the youth were not afforded due process protections. They were instead required to attend a meeting with the team of staff members who imposed the added time or transfer. A number of the youth reported that they had no access to attorneys for the meetings, their parents were not notified before the meetings, and they could not challenge the decision. These measures are especially problematic because the State's juvenile court retains jurisdiction over juvenile delinquency cases post-adjudication and after determining the appropriate placement facility for a child. FLA. STAT. § 985.0301, 985.441, 985.455. The juvenile code prohibits a child's extended confinement to a program for punitive reasons. FLA. STAT. § 985.455 (3) ("The child's length of stay in the program shall not be extended for purposes of sanction or punishment."). Additionally, DJJ must seek court approval and notify the child's attorney of its intent to transfer the child between facilities of higher or lower restrictiveness levels. FLA. STAT. § 985.441. The transfer may proceed without court authorization only if the court fails to respond after 10 days within the receipt of notice. FLA. STAT. § 985.441. Moreover, because the disposition and transfer decisions are within the traditional purview of the court, the youth have a constitutional right of access to the juvenile court and access to counsel. John L. v. Adams, 969 F.2d 228, 233 (6th Cir. 1992). The administrators at NYFDC circumvented this process by referring to the planned administrative merging of the facilities and calling the process a "reassignment" as opposed to a transfer. Regardless of how it was labeled, youth at Dozier – a high risk facility – were being moved to a maximum-risk facility without court notice or approval. The later wholesale removal of Dozier youth to JJOC before the closure announcement was similarly punitive and improper.

Third, the measures did not take into account the safety of the youth when they are subjected to either lengthened time in confinement or time in the more restrictive confinement. While the measures were supposedly implemented to address fighting and improve safety, such considerations were absent in the actual implementation of the measures. Confined youth retain their right to personal security and safety. Youngberg, 457 U.S. at 315; Jarrard, 786 F.2d at 1085; Taylor, 818 F.2d at 795. At Dozier, youth automatically received extended confinements if they were deemed to have started a fight. There was no consideration of the harm that can be caused to a youth forced to remain in custody beyond his release date. There was also no consideration of the safety risks to youth transferred from Dozier to JJOC. The most basic concern, classification separation, was overlooked. For example,

the primary separation appeared to be that youth in different categorization levels were identified by different colored jumpers. This form of separation apparently was not enforced, as we observed youth of different category levels intermingling at JJOC. In one particularly egregious instance, a youth who had been propositioned for oral sex by another youth was transferred to JJOC along with his tormentor. According to the incident report, the youth, JJ, told staff that the other youth made sexual advances toward him. Staff initially moved the other youth to a different cottage. The other youth was subsequently transferred to JJOC following several infractions unrelated to his advances toward JJ. Next, JJ was transferred to JJOC after several rule violations. We saw no evidence that the youths' prior history was factored into the decision to move JJ to the same facility as his tormentor or to ensure that they were appropriately separated.

Finally, these punitive measures were counterproductive to the rehabilitation of Dozier youth. The extensions and transfers, while ostensibly serving as a deterrent to fighting, were so unfair that a number of the youth resorted to self-destructive behavior. The penalties were an excessive response to youth who acted out and, instead, contributed to the youths' aggressive behaviors. In this respect, the extensions and transfers contributed to feelings of hopelessness, anger, and aggression. In the incident report involving GG, for example, GG reported that he was upset and ready for prison after he had received a 120-day extension. Staff restrained another transferred youth, JJ, in approximately seven incidents over the course of a few weeks while the youth was confined at JJOC; some of those incidents involved self-injurious behavior. The extensions and transfers did not address the rehabilitative needs of the youth and violated their constitutional rights.

6. Unconstitutional Frisk Searches

Juveniles do not give up their Fourth Amendment right to bodily integrity when they are confined to a juvenile facility. See Bell, 441 U.S. at 558 (applying Fourth Amendment reasonableness standard to searches of pre-trial detainees); Justice v. City of Peachtree, 961 F.2d 188 (11th Cir. 1992)(noting that the Fourth Amendment prohibits unreasonable searches even in custodial searches). In evaluating the reasonableness of institutional searches, courts balance the scope of the intrusiveness, the manner of the search, the location of the search, and the justification for the search. Bell, 441 U.S. at 559. Even a pat down search is “a serious intrusion upon the sanctity of the person, which may inflict great indignity and arouse strong resentment, and it is not to be undertaken lightly.” Terry v. Ohio, 392 U.S. 1, 17 (1968). Facility searches must be reasonably based on safety and security concerns and limited in scope to address those concerns. Bell, 441 U.S. at 559. Moreover, the manner of the search must not be overly intrusive in relation to the justification for the search. Id.

Dozier youth were subjected to frisk searches more than 10 times per day, purportedly for recovery of contraband. During the six month period we reviewed, the most dangerous contraband recovered were pencils, which constituted 52 percent of the recovered contraband. Occasionally, staff uncovered drawings, writing paper, and food during frisk searches. The searches occurred as a matter of course -- even when the children were under constant staff supervision. For example, in a typical day, youth were frisked (i) before breakfast, (ii) after breakfast, (iii) after medication rounds, (iv) during a school break, (v) before lunch, (vi) after lunch, (vii) during a second school break, (viii) during sick call, (ix) before dinner, (x) after dinner, and (xi) whenever they left the cottage for recreational activities. Many of the youths informed us that some ROs were especially intrusive in conducting the searches. We heard a number of reports of youth being groped by ROs during the searches. One youth noted, "Some staff rub on your privates." Another stated, staff "touch too much."

These repeated searches were unduly intrusive and not supported by the stated justification. The repetitive searches were unwarranted, especially when the youth had not left the grounds, had not been visiting outsiders, and were under constant observation by the staff. Moreover, there were simple alternatives to uncovering contraband without resort to frequent and intrusive searches. For example, as the court noted in N.G., 382 F.3d at 234 n.13, where pencils and other writing material can be numbered and the recipient's name recorded so that missing items can be traced to a particular youth, a more targeted pat-down search of that youth would be reasonable. Similarly, the staff could count the silverware before and after meals to make sure that none was improperly taken.

7. Inadequate Medical And Mental Health Services

The State must provide juveniles held in its facilities with adequate medical and mental health treatment. Youngberg, 457 U.S. at 323-24; Jarrard, 786 F.2d at 1086; Bozeman, 422 F.3d at 1265; Cook, 402 F.3d at 1115. Before closing the facilities, the State had made significant improvements to the medical care of Dozier and JJOC youth by hiring a fulltime doctor and additional nurses. However, additional improvements were required in several areas, specifically (1) access to sick call (Dozier); (2) delivery of medical care to youth in the BMU; (3) adequate mental health care (Dozier and JJOC); and (4) adequate CPR training (Dozier).

At Dozier, youth had to request sick call forms from the direct care staff. This presented a problem when youths sought to complain about inappropriate physical treatment by a RO. Confined youth should have the ability to complete a sick call request without the interference of staff. Second, youth in the BMU did not receive adequate medical care, assessment of their mental health after their arrival in the BMU, or assistance in determining whether they should be discharged from the BMU. Youth confined to the BMU were severely

isolated and required regular medical and mental health care. Third, the youths' mental health diagnoses and care were very suspect given the predominant "conduct disorder" diagnoses. The mental health care staff were not adequately consulted on decisions that were necessary to the mental health of the youth. As discussed above with respect to isolation issues, extensions of confinement, and transfers to JJOC, the insufficient input of the mental health staff in these decisions was harmful to the mental well-being of Dozier youth. At JJOC, youth who had been transferred from Dozier were unable to see their counselors. Indeed, many of the boys had not received their individual counseling or even their group counseling. Finally, CPR training was not available for Dozier's medical staff. This created an easily avoidable and unnecessary danger to the youth.

8. Failure To Provide Necessary Rehabilitative Services

The State is required to provide youth with necessary rehabilitative treatment. Youngberg, 457 U.S. at 322 (confined person with intellectual disabilities is "entitled to minimally adequate training" as may be reasonable to protect his safety and freedom from unreasonable restraints); Nelson v. Heyne, 491 F.2d 352 (7th Cir. 1974) (holding that detained juveniles have a right to rehabilitative treatment). The DJJ failed to do so in several respects. First, Dozier and JJOC's direct care staff were not appropriately trained in adolescent development and de-escalation measures. We found that much of the staff had not been trained in communication skills, de-escalation techniques, mental health issues, adolescent development, or behavior management. As the Supreme Court has recognized, adolescents have unique psychological needs and should not be treated in the same manner as adults. See Graham v. Florida, 130 S. Ct. 2011, 2026 (2010) (noting neurological studies showing that "parts of the brain continue to mature through late adolescence" and that "juveniles are more capable of change than are adults."). In order to provide appropriate rehabilitative care, direct care staff working with juveniles and their supervisors should understand adolescent development processes and learn how to interact with youth in a manner that reinforces positive behavior.²⁴

²⁴ Staff pay may have been a contributing factor to the direct care staff's poor attitude toward their training and developing a better understanding of the youth within their care. We learned that the average pay of direct care staff fell below \$12 per hour and that some supplemented their salary with a second job. This is below the industry average. According to the Bureau of Labor Statistics of the U.S. Department of Labor, the median hourly wage for correctional and detention officers is \$18.78, an annual salary of \$39,050. See <http://www.bls.gov/oes/current/oes333012.htm>. The site does not list juvenile facility salaries. Other reporters indicate that the minimum hourly rate for juvenile facility staff is more than \$12 per hour. See e.g. http://www.payscale.com/research/US/Job=Juvenile_Detention_Officer/Hourly_Rate

Next, the basic therapeutic needs of the youth were not being met. As noted in the above discussion on suicidal youth, many of the youth were not being properly diagnosed for potential behavioral disorders. At Dozier, for example, more than 98% were generically diagnosed as having a “conduct disorder.” The youth need to be properly diagnosed and to receive the proper corresponding treatment. In addition, many of the youth who qualified for substance abuse treatment were not receiving such treatment. In April 2010, only 10.7% of Dozier youth were provided with substance abuse treatment although 93% of them qualified for treatment.

Finally, the NYFDC youth had insufficient exercise and structured activities to contribute to their positive behaviors and medical and mental wellbeing. Exercise and recreational activities are vital components of a youth’s rehabilitation. See e.g. Mary Ellen O’Connell et al., *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*, National Research Council and Institute of Medicine of the National Academies, 17 (2009) (“The prevention of [mental, emotional, and behavioral] disorders and physical disorders and the promotion of mental health and physical health are inseparable.”); National Commission on Correctional Health Care Services in Juvenile Facilities, Standard YF 3, (2004)(requires that juveniles receive at least one hour of large muscle exercise per day, including walking, jogging, basketball, and other aerobic activities). At NYFDC, youth spent a significant amount of time being idle. Oftentimes, ROs canceled outdoor exercise opportunities, claiming that the heat index was too high, without replacing such activities by allowing the youth access to the Dozier gymnasium. Facilities for adequate exercise programs were available on the Dozier campus. The problem was that the facilities were not consistently offered to the youth. On the JJOC side, the boys were confined to their pods and did not receive consistent opportunities for large muscle exercise. On both campuses, many of the youth were unable to engage in constructive recreational activities because basic supplies, such as board games and sporting equipment, were often unavailable.

The failure to address these concerns not only harms the youth, but has a negative impact on public confidence and public safety. The critical role of the juvenile justice system to correct and rehabilitate is being abdicated, and youth may well be leaving the system with additional physical and psychological barriers to success. FLA. STAT. § 985.01(b)(Stating that the purpose of the juvenile code is to “provide for the care, safety, and protection of children in an environment that fosters healthy social, emotional, intellectual, and physical development; to ensure secure and safe custody; and to promote the health and well-being of all children under the state's care”).

(showing an hourly rate between \$12.19 to \$17.69) and <http://www.simplyhired.com/a/salary/search/q-juvenile+guard> (showing an average annual salary of \$45,000).

9. Unlawfully Unsanitary And Unsafe Conditions At Dozier

Confined youth are entitled to safe and sanitary living conditions. Youngberg, 457 U.S. at 316; Gary H., 831 F.2d at 1433 (approving consent decree requirement of minimum sanitary conditions in a facility for juvenile detainees). We observed sanitation deficiencies in the living areas, dining area, and educational areas of the Dozier campus. First, there was no program in place to address the cleanliness of the cottages. As such, youth complained of insects and rodents as an ongoing problem. Our review also revealed dirty living quarters, including evidence of insects and dirty toilets. An inspection of the kitchen revealed rodent droppings on the canned food. Many of the youth complained that they (and others) found insects and other foreign objects in their food, a clearly problematic condition. See e.g. Alexander S., 876 F.Supp. at 787 (finding that “food containing cockroaches and other foreign matter falls below what may be deemed minimally adequate.”). Finally, the educational areas were not cleaned regularly, sharp objects such as staples were not securely stored in the classrooms, and basic provisions for cleanliness, such as soap and spill kits were not readily available. A number of the first aid kits had broken seals and were not adequately stocked with supplies. A simple system could have been implemented to restock the supplies and avoid unnecessary delays in emergency care.

IV. CONCLUSION

The constitutional violations outlined above are the result of the State’s failed system of oversight and accountability. To protect the youth in its remaining facilities, the State must take immediate measures to assess the full extent of its failed oversight with the assistance of consultants in juvenile protection from harm issues. The State must also strengthen its oversight processes by implementing a more rigorous system of hiring, training, and accountability.