June 8, 2005

The Honorable Brad Henry
Governor
State of Oklahoma
State Capitol Building
2300 N. Lincoln Blvd., Room 212
Oklahoma City, OK 73105

Re: Investigation of the L. E. Rader Center,
Sand Springs, Oklahoma

Dear Governor Henry:

I write to report the findings of the Civil Rights Division's investigation of conditions at the L. E. Rader Center ("Rader") in Sand Springs, Oklahoma. On March 31, 2004, we notified you of our intent to conduct an investigation of Rader pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, and the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141 ("Section 14141"). As we noted, both CRIPA and Section 14141 give the Department of Justice authority to seek a remedy for a pattern or practice of conduct that violates the constitutional or federal statutory rights of children in juvenile justice institutions.

The level of cooperation from the Office of Attorney General ("OAG") has been mixed. The OAG provided the United States with some of the documents we requested. Specifically, the OAG provided us with incident reports, youth grievances, disciplinary reports, and abuse investigations from January 1, 2003 to May 30, 2004. The OAG would not, however, produce the medical reports that the facility generated during the same time period. The lack of medical reports severely limited our ability to assess the number and severity of injuries that youth at Rader suffered following juvenile assaults, staff abuse, and incidents of self-injurious behavior.

More importantly, the OAG refused to allow the United States the opportunity to tour the Rader facility to observe operations and interview staff and residents. From April 2004 to February 2005, the United States attempted to work with the OAG to address any concerns and ensure that our tour would not disrupt operations at Rader. The OAG repeatedly refused to permit the United States to tour the facility. This lack of cooperation severely impeded our investigation.

By law, our investigation must proceed regardless of whether officials choose to cooperate fully. Indeed, when CRIPA was enacted, lawmakers considered the possibility that state and local officials might not cooperate in our federal investigation. See H.R. CONF. REP. 96-897, at 12 (1980), reprinted in 1980 U.S.C.C.A.N. 832, 836. Such non-cooperation is a factor that may be considered adversely when drawing conclusions about a facility. See id. We now draw such an adverse conclusion.[1]

Consistent with the statutory requirements of CRIPA, I now write to advise you of the findings of our investigation, the facts supporting them, and the minimum remedial measures that are necessary to address the deficiencies we have identified. As described more fully below, we conclude that the conditions of confinement violate the constitutional rights of youth confined at Rader. In particular, we find that, based on constitutionally deficient practices, Rader fails to protect children from harm or the risk of harm.

I. BACKGROUND

The State of Oklahoma ("State"), through its Office of Juvenile Affairs ("OJA"), operates Rader, the largest secure juvenile justice facility in the State. Rader has bed space for approximately 215 juveniles who have been adjudicated delinquent and are 19 years of age or younger. Although Rader housed both male and female youth at the inception of our investigation, recent news reports indicate that OJA removed all girls from the facility in February 2005.

II. FINDINGS

As a general matter, States must provide confined juveniles with reasonably safe conditions of confinement. See Youngberg v. Romeo, 457 U.S. 307, 315-24 (1982); Bell v. Wolfish, 441 U.S. 520, 535-36 & n.16 (1979). As the Tenth Circuit stated in Yvonne L. v. New Mexico Dept. of Human Serv., 959 F.2d 883 (10th Cir. 1992), "juveniles involuntarily placed in a private school by state agencies or a court [have] liberty interests protected by the Fourteenth Amendment; specifically, '[s]uch [a] person has the right to reasonably safe conditions of confinement.'" Id. at 893-94 (quoting Milonas v. Williams, 691 F.2d 931, 942 (10th Cir. 1982)). As described below, the State has fallen far short of this constitutional obligation.

Our investigation revealed that the State fails to protect youth confined at Rader from harm due to constitutionally deficient practices. Specifically, the State fails to

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[1] The State's non-cooperation constitutes only one factor that we consider in preparing our statutory findings and recommendations. We also have considered the documentation provided by the State, reports issued by the American Correctional Association ("ACA"), news articles, and interviews with private attorneys, public defenders, and local law enforcement officers.

protect youth from: (1) sexually inappropriate relationships with staff and other juveniles; (2) juvenile-on-juvenile violence; (3) self-injurious behavior; (4) inadequate management of psychotropic medication; and (5) excessive use of force by staff.[2]

A. Sexually Inappropriate Relations

Contrary to its legal obligations, the State fails to provide adequate supervision and monitoring to ensure that juveniles at Rader are not subjected to inappropriate sexual relationships with staff or other residents. See Youngberg, 457 U.S. at 324; Yvonne L., 959 F.2d at 893.

1. Sexual Relationships Between Staff and Youth

Documents produced by the State indicated that numerous sexual relationships developed between female staff members and male youth. It appears that in some instances other staff members were aware of these relationships and brought them to the attention of supervisors and administrators. However, administrators and supervisors failed to take prompt, appropriate action. Examples of inappropriate sexual relationships between staff and youth include:

- On May 31, 2004, a male youth reported to a client advocate at Rader that a female staff member permitted a youth to carry her into his room and place her on his bed where the youth and others fondled her.[3] The youth reported that the female staff member previously spoke in a sexual manner with youth and permitted them to touch her in inappropriate ways. The documents we received from the State did not indicate whether an internal investigation substantiated the youth's claims regarding the alleged sexual contact, and if so, whether any disciplinary action was taken.

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[2] Except where specifically noted, internal Rader investigations and/or investigations conducted by the Office of Client Advocacy ("OCA") of the Oklahoma Department of Human Services provide the basis for all allegations set forth in this letter.

[3] A "client advocate" is a staff member at Rader who refers allegations of misconduct to administrators, assists youth with grievances, and represents youth in discipline hearings.

- In the Fall of 2003, female staff member A.W.[4] and a male youth engaged in a sexual relationship. Rader staff found correspondence between the two that confirmed the relationship.[5]

- In September 2003, female staff member N.R. engaged in a sexual relationship with male youth J.J., who was classified as a sex offender. Staff member N.R. and youth J.J. twice engaged in oral sex and digital penetration in the linen closet of the mental health stabilization unit. Staff member N.R. also permitted a different youth, D.Q., to fondle her in front of other youth on the unit. Youth J.J. became very territorial of the staff member and had numerous physical altercations with other youth over her.[6] At least eight staff members voiced their concerns to staff member N.R. and to supervisors about staff member N.R.'s behavior. Indeed, one staff member stated that he considered the female staff member to be a "sexual predator." Documents provided by the State indicate that OCA confirmed sexual abuse by staff member N.R.[7] We requested but were not provided documentation regarding any discipline or corrective action taken by the State following this incident.

- Between July 2003 and October 2003, female staff member B.K. and a male youth engaged in inappropriate sexual relations. Staff observed staff member B.K. use her foot to rub the inner thigh of the youth while the two were seated in the day room of the unit. Staff also noted that staff member B.K. spent a great deal of time in the youth's bedroom. Indeed, one staff observed staff member B.K. lying on the youth's bed. Staff reportedly noted the inappropriate relationship early on, yet failed to report it to administrators. Administrators took action to address the relationship after a security staff member intercepted a letter from staff member B.K. to the youth. The letter contained sexually explicit language and included the

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[4] In this letter, we use pseudonym initials of youth and staff in order to protect their identities and privacy.

[5] The OJA Office of Public Integrity ("OPI") conducted an investigation of staff A.W. and found the letters in the course of that investigation. The State did not provide documents from the OPI investigation, so we do not know what action, if any, was taken by the State.

[6] For example, youth J.J. noticed youth L.M. staring at the female staff. Youth J.J. leaped on to a table and kicked youth L.M. in the face.

[7] OJA refers many allegations of staff misconduct to the OCA. The OCA either conducts its own investigation or sends the matter back to OJA for Rader staff to investigate.

female staff member's home phone number. Documents provided by the State indicate that OCA confirmed sexual abuse by staff member B.K. Staff member B.K. resigned her employment on October 8, 2003.

- From September 2002 through February 2003, a male youth and female staff member R.G. engaged in a sexual relationship. During this six month period, there was abundant indicia of inappropriate behavior. For example: the female staff member frequently shared her food with the youth; she brought him electronic games and other "goodies;" the youth sent letters to the female staff member at her home address; the female staff member mailed Valentine's Day cards to the youth at Rader; she gave the youth photos of herself; she brought him into the supply closet with her; she entered the youth's room after lights out; she permitted the youth to stay up after hours and spend time with her; she permitted the youth to wear her clothes and shoes; she allowed the youth to place his hand on her thigh in front of other youth; and the female staff member and the youth engaged in horseplay such as swatting and slapping. During this time, three different staff members spoke with the female staff member and other employees wrote memoranda setting forth their concerns about her behavior. Nevertheless, it took six months for administrators to address the relationship. Documents provided by the State indicate that OCA confirmed a finding of sexual abuse against the female staff member. The State terminated staff R.G.'s employment on February 20, 2003.

2. Sexual Relationships Between Youth

Examples of inappropriate sexual relationships between youth include:

- On April 3 and 4, 2004, two male youth reportedly engaged in mutual masturbation while housed on the unit for sex offenders. One of the youth reported that he participated because he feared the other youth would harm him.[8]

- On January 29, 2004, an 18-year-old male youth engaged in anal sex with a 14-year-old male in the restroom of the gym while two staff supervised 13 other youth. The incident occurred while one of the youth was on

[8] We did not receive a final investigation report from the State regarding this incident. The documents we received indicate that an investigation of this incident was ongoing and that investigators had not reached a final conclusion as to whether the conduct occurred.

"close observation" which required staff to know of his whereabouts at all times.[9]

- In August 2003, two female youth engaged in sexual activity in their dormitory on at least one occasion. The two youth were able to engage in sexual activity because there was only one staff member monitoring the housing unit. The other staff member had left the unit to take a smoking break, in contravention of facility rules. Documents provided by the State indicate that OCA substantiated a finding of caretaker misconduct on the staff member who was derelict from duty. Rader suspended the staff member for three days without pay.

- From at least May 2003 through June 2003, two male youth engaged in a sexual relationship while housed on the sex offender unit. The two youth regularly paired off and engaged in mutual masturbation and oral sex while staff were preoccupied with other youth. Documents provided by the State indicate that OCA substantiated a finding of neglect against one staff member. Rader suspended the staff member for three days without pay.

- On January 26, 2003, two youth classified as sexual offenders left the day room of their unit and entered one of the bathrooms. The two youth then engaged in oral and anal sex. Although three staff were on duty, two staff were dealing with a youth who was acting out in his room and the third staff was monitoring the day room. OCA investigated the incident and did not confirm caretaker misconduct, but did confirm sexual activity.

B. Youth-on-Youth Violence

The State must provide youth confined at juvenile justice facilities with reasonably safe conditions including protection from assault by other youth. See Youngberg, 457 U.S. at 324; Yvonne L., 959 F.2d at 893. Incident reports provided by the State between January 1, 2003 and May 30, 2004, demonstrated that a significant number of juveniles were involved in youth-on-youth violence.[10] Many of the assaults

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[9] Documents provided by the State indicate that OCA did not confirm any allegations of neglect against the staff members charged with supervising the youth, but did confirm that sexual activity had occurred.

[10] We are aware that the ACA reaccredited Rader in September 2003. We are also aware that the ACA conducted one-day monitoring tours of Rader in September 2004 and March 2005 in response to problems identified in a report by the Oklahoma Commission on Children and Youth. Following the March 2005 tour, the ACA issued a report in which it noted a downward trend in the level of violence at Rader. Without touring the facility, however, we are unable to verify whether a meaningful reduction in

and injuries at Rader occurred because staff failed to adequately supervise youth. Other assaults and injuries occurred because staff lacked the knowledge and/or training to safely intervene once fights occurred. Except where indicated, the following examples are taken from the documents provided by the State:

- On June 18, 2004, a local newspaper reported that a brawl broke out among seven youth who were members of rival gangs. One youth suffered a broken jaw and another youth suffered a broken arm. Five other residents were injured. Ten staff members were taken to a local hospital to treat injuries they suffered.

- On May 16, 2004, youth T.E. and youth G.L. argued at the gym. In response, staff sent the two youth back to the dorm. Inexplicably, staff sent them to the dorm unescorted. When they arrived at the dorm, youth G.L. attacked youth T.E. The one staff person on duty in the dorm refused to break up the fight. Instead, she ordered other juveniles to intervene. Youth T.E. received a bruised left eye from this incident. Documents provided by the State indicate that OCA requested that Rader officials investigate the incident. To the extent that an internal Rader investigation exists, the State did not provide us with a copy.

- On May 14, 2004, youth F.D. and youth P.Z. fought for several minutes in youth P.Z.'s bedroom. The fight continued until another youth, M.B., broke it up. Youth F.D. suffered two black eyes from the incident. Staff were unaware that the fight had occurred. Documents provided by the State indicate that OCA requested that Rader officials investigate the incident. To the extent that an internal Rader investigation exists, the State did not provide us with a copy.

- On May 8, 2004, youth E.N. and youth G.L. entered the bathroom and began to fight. Staff were not aware that the fight had occurred until other youth told staff that youth G.L. was in the bathroom and that his nose was bleeding. Rader staff transported youth G.L. to the emergency room where medical personnel determined that he had a broken nose. Documents provided by the State indicate that OCA would conduct an investigation. To the extent that OCA did conduct an investigation, the State did not provide us with a copy.

- On May 7, 2004, youth H.R. approached youth P.Z. from behind, choked him, and slammed him to the ground. Youth P.Z. claimed that there were staff in the room, but they did not intervene. Instead, another youth eventually broke up the fight. Youth P.Z. suffered a black eye from the

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violence has occurred.

incident. Documents provided by the State indicate that OCA requested that Rader officials investigate the incident. To the extent that an internal Rader investigation exists, the State did not provide us with a copy.

- On April 29, 2004, a series of youth-on-youth assaults occurred on the Mental Health Stabilization Unit ("MHSU"). Staff stated in incident reports that: "We did not/do not believe that we can keep juveniles on this unit safe."

- On January 17, 2004, youth A.C. claimed that three youth entered his room and assaulted him. Youth A.C. claimed that several minutes passed before staff realized what was happening and responded to the incident. Youth A.C. suffered an abrasion above his right eye from the incident. Documents provided by the State indicate that OCA requested that Rader officials investigate the incident. To the extent that an internal Rader investigation exists, the State did not provide us with a copy.

- On November 24, 2003, youth V.S. assaulted youth J.J. in the shower. The OCA investigated the incident and confirmed that inadequate staff supervision made it possible for the assault to occur. Rader staff took youth J.J. to the emergency room where he received treatment for bruises to his body. OCA confirmed a charge of caretaker misconduct against staff D.U., and staff D.U. received a written reprimand and a corrective action plan.

- On July 30, 2003, youth K.V. assaulted youth I.O. while staff W.T. and staff C.X. were on duty. Staff W.T. intervened and all three fell to the floor. Staff W.T. restrained youth K.V. and released youth I.O. Several residents kicked youth K.V. and staff W.T. while they lay on the floor. Documents produced by the State indicate that staff C.X. did not attempt to assist staff W.T. or protect youth K.V. OCA confirmed a charge of neglect against staff C.X., and staff C.X. received a three-day suspension without pay and a corrective action plan.

Disturbingly, and in a gross departure from sound practices, it appears that in some cases the staff either actively encouraged a fight to occur or had knowledge that a fight would occur and allowed it to happen. For example:

- On April 16, 2004, youth Y.A. assaulted youth O.U. in the kitchen area while four other youth watched. Youth O.U. suffered facial bruises, a bloody nose and mouth, and a cut on his neck. The youth claimed that a staff member, who was seated only a few feet away when the fight occurred, permitted the fight to continue. Documents provided by the state indicate that OCA confirmed staff neglect and inadequate supervision of youth. The documents also indicate that the staff member

is no longer employed at Rader. It is unclear from the documents, however, whether Rader terminated the staff member as a result of this incident or whether he left employment voluntarily.

- On February 14, 2004, a staff member verbally encouraged youth J.J. and youth B.G. to settle their differences by going into their cells and fighting. The staff member stood outside the locked cell door and watched as the two youth fought. The staff member did not unlock the door and intervene until after youth B.G. grabbed youth J.J.'s head and brought it down on his knee.[11] Rader staff transported youth J.J. to the emergency where medical staff diagnosed him with a broken nose and a closed head injury with a bruise to his left eye and forehead. Documents provided by the State indicate that OCA confirmed the allegation of abuse with injury. In addition, the OCA investigation indicated that the staff member verbally encouraged the alteration and observed part of the fight. We requested but were not provided documentation regarding any discipline or corrective action taken by the State following this incident.

There are other indications that the State fails to properly supervise youth at Rader. A local newspaper reported on October 24, 2004 that 15 youth had escaped from Rader or gone AWOL. Indeed, the article stated that on October 16, 2004 two youth escaped from Rader by prying open a locked door and scaling the facility's perimeter security fence. Most recently, the newspaper reported that on March 13, 2005, two 14-year-old youth escaped from Rader by overpowering a staff member, stealing her keys, and scaling two different fences.

Finally, the lack of adequate supervision makes it possible for an excessive quantity of contraband to be introduced into the facility. The failure to adequately control contraband places both staff and youth at risk of harm. See LaMarca v. Turner, 995 F.2d 1526, 1532-37 (11th Cir. 1992) (finding that excessive contraband contributes to an unsafe environment for inmates). In an institutional setting, contraband is often used either as a weapon or as currency. According to documents provided by the State, contraband appears to be readily accessible to juveniles at Rader, and is regularly used as a weapon, potential weapon, or currency in the facility. For example:

- On September 19, 2004, a youth attacked another youth and a staff member with a four-foot long piece of metal.

- In May 2004, staff searched a youth's room and found a metal rod hidden in his mattress.

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[11] Youth also reported that the staff members on duty spoke about reporting the incident as either horseplay or an accident in the shower. Neither staff member filed reports about the incidents although they were required to by facility rules.

- In October 2003, staff searched the girls' unit and found drugs and drug paraphernalia.

- In June 2003, staff searched a youth's room after he had taken a psychotropic medication intended for another youth. In his room, they found, among other things, batteries and bleach.[12]

- In May 2003, three youths tested positive for marijuana. A search of a youth's room uncovered marijuana and a lighter.

- In April 2003, staff found a razor blade hidden in a vent in a youth's cell.

- On January 6, 2003, staff searched the room of a male youth and found money, rolling papers, cigarettes, a lighter, pornography, materials used in making tattoos (including a bloody rag), and pills.

C. Self-Injurious and Suicidal Behavior

The State also fails to protect youth at Rader who engage in suicidal and self-injurious behavior. See Youngberg, 457 U.S. at 324; Yvonne L., 959 F.2d at 893.

1. Suicide

In 2003 and 2004, youth at Rader made at least 12 suicide attempts at the facility. In each case, staff failed to take adequate precautions to protect the youth from harm. For example:

- On March 21, 2004, a youth cut his wrist with the metal from a pencil eraser and pulled out stitches previously sutured. With the blood from his wounds, the youth wrote the words "with pain" and "die" on the wall over his bed. The youth then used a rope made from a towel and his shirt and tried to strangle himself. OCA investigated the incident and did not confirm neglect by the staff members supervising the youth.[13]

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[12] A youth could make a weapon by placing the batteries in a sock and swinging the batteries at an individual. Further, a youth easily could harm himself or others by swallowing or hurling bleach. Indeed, one youth attempted to poison a staff member by pouring bleach into the beverage of a staff member.

[13] The OCA investigators accepted the staff members' representations that they checked on the youth every 15 minutes. However, the staff members failed to document these checks. Indeed, they claimed that they were not required to document the checks even though facility policy explicitly requires staff to do so.

- On February 24, 2004, a youth went to his room, closed the door, tied his belt around his neck, and tried to hang himself. Staff did not realize that the youth was attempting suicide until he fell to the ground and yelled out in pain, as he had chipped a bone in his ankle. An internal investigation confirmed that staff failed to properly supervise the youth. We requested but were not provided documentation regarding any discipline or corrective action taken by the State following this incident.

- On August 19, 2003, a youth on the MHSU cut himself and staff placed him on suicide watch. On August 20, 2003, the youth, who was on "close observation," went to his room without supervision and closed the door. Once alone, he tore up his shirt, fashioned the strips into a noose, and tied it around his neck. Staff found the youth lying on the floor of his room with red marks around his neck.[14] OCA investigated the incident and did not confirm neglect by the staff members supervising the youth.

- On April 10, 2003, staff discovered that a youth had tried to commit suicide by tying a string about his neck. At the time, the youth was on suicide watch and wearing a helmet and suicide smock to prevent acts of self harm. The youth had tied a string to his helmet, wound it around his neck, and tied the string to his toe. Staff discovered the youth while distributing medication. A staff member was unable to untie the string and, instead, burned the string with a lighter he was carrying. Documents provided by the State do not indicate whether either OCA or Rader officials investigated the incident.

  Two months earlier, on February 8, 2003, staff found the same youth underneath the desk in his cell. Staff initially thought that he was sleeping. However, he would not respond to verbal commands to wake up. Staff soon realized that the youth was unconscious and had wrapped a shoelace around his neck and attached it to his toe. A staff member used a lighter to burn the shoelace. Documents provided by the State do not indicate whether either OCA or Rader officials investigated the incident.

- On January 16, 2003, a youth cut both his wrists with a piece of metal. Staff placed the youth in the day room for closer observation. An hour later, the youth tried to strangle himself by tying his pillow case around his neck and strangling himself. Documents provided by the State do not indicate whether either OCA or Rader officials investigated the incident.

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[14] At the time of the incidents, the mental health stabilization unit did not have policies or procedures governing its operations.

2. Self-Injurious Behavior

In addition to the attempted suicides, we found many examples of youth who engaged in self-injurious behaviors. From January 1, 2003 to May 30, 2004, there were over 35 documented reports of youths punching walls or furniture, banging their heads against floors and windows, or beating themselves with objects. In most cases, it appears that staff at Rader are not monitoring adequately children who have a repeated history of engaging in self-abusive behaviors. The injuries ranged from bruises and scratches to fractures.[15] For example:

- On May 28, 2004, a male youth on close supervision managed to wander into an unauthorized area. The youth became upset and struck a window. Rader transferred the youth to the hospital where medical staff stitched the wound.[16] In the 18 months prior to this incident, the youth repeatedly engaged in self-injurious behavior. Incident reports document seven instances where the youth struck an inanimate object; five instances where the youth inserted metal into his skin and/or used metal to cut himself, and one instance where he swallowed ink.

- On May 5, 2004, a male youth inserted a two-inch section of paper clip into his left forearm. Staff did not realize this until three days later.[17] Staff should have been more vigilant to prevent the youth from hurting himself given that the youth had harmed himself numerous times before. In the nine months prior to this incident, the youth twice punched out the windows in doors and at least five times either cut himself or inserted metal into his skin. During one incident, staff heard the youth singing "cut, cut, cut!" in his room. Staff entered the room and found that he had cut a "gaping hole" in his arm. At the time, the youth was supposed to be on close observation because of an incident earlier in the day in which he was sent to the hospital after inserting a paper clip under the skin in his arm.

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[15] Youth appear to have engaged in these behaviors either to hurt themselves or to vent their frustrations. For example, on May 1, 2004, when staff asked a youth about a bruise on his head, he stated that he had beaten his head against the wall in order to relieve stress.

[16] Documents provided by the State indicate that OCA requested that Rader officials investigate this incident. To the extent that an internal Rader investigation exists, the State did not provide us with a copy.

[17] Documents provided by the State indicate that OCA requested that Rader officials investigate this incident. To the extent that an internal Rader investigation exists, the State did not provide us with a copy.

D. Failure to Safely Distribute Psychotropic Medication

The State fails to monitor adequately the distribution of psychotropic medication to mentally ill youth at Rader. See Youngberg, 457 U.S. at 324. See also Coleman v. Wilson, 912 F.Supp. 1282, 1309-10 (E.D. Ca. 1995) (finding defendants' system of medication management unconstitutional based, in part, on their failure to monitor adequately the hoarding of psychotropic medication). Based on a review of documents produced by the State, we found that students regularly hoard medication and either share it with or sell it to other youth. In addition, the nursing staff, at times, appear to provide youth with the inappropriate type or dosage of medication. For example:

- In April 2004, staff found a male youth sitting in a chair in his room. The youth was non-responsive to verbal commands. The staff shook him, but he would not respond. Rader staff transported the youth to the hospital. Documents provided by the State indicate that the youth had consumed seven pills of prescription medication prescribed to another youth.

- In September 2003, a youth provided two pills of a psychotropic medication and two pills of an anti-depressant to two other youth who crushed the pills and snorted them.

- On August 11, 2003, a male youth swallowed eight pills during medication distribution. Over a two-week-period the youth had “cheeked” some of his own medication and had received prescription medication from other youth.[18] The youth hid the medication in his room.

- On July 20, 2003, a male youth provided 13 pills to three other youth. The three youth took the pills without knowing what they were. One youth, with slurred speech, informed staff that he wanted to fly like Superman.

- On June 17, 2003, a male youth took a psychotropic mediation that was meant for another youth. He was taken to the hospital for detox.

- On May 3, 2003, a nurse gave a male youth the wrong medication during pill distribution. The youth informed the nurse that it was the wrong medication, but the nurse insisted that it was correct. The nurse later realized that the youth had, in fact, received the wrong medication.

E. Excessive Force by Staff

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[18] A youth “cheeks” oral medications by hiding the medication either in the cheek or under their tongue to prevent swallowing. The youth later spits out the medication and either hides it, gives it away, or sells it to another youth.

Staff at Rader physically restrain youth with great frequency. Staff legally are permitted to employ physical force when youth pose an immediate risk of harm either to themselves or to others. See Youngberg, 457 U.S. at 324; Yvonne L., 959 F.2d at 893; Milonas, 691 F.2d at 942-43. The amount or level of force used, however, should be the least amount necessary to control the situation and prevent injury to staff and youth. Our review of documents produced by the State indicates that Rader staff employed force that was disproportionate to the threat posed by the youth. The following examples are illustrative:

- On March 15, 2004, in response to male youth R.W. trying to push past him, staff E.V. picked him up and threw him to the ground on his back. The youth, who is six inches shorter and weighs 100 pounds less than the staff member, suffered a one-inch cut over his eye that required three sutures to close as well as bruises and abrasions. An OCA investigation confirmed staff misconduct by staff E.V. We requested but were not provided documentation regarding any discipline or corrective action taken by the State following this incident.

- On December 12, 2003, a female staff member and a male youth argued over the placement of his bed in the day room. At one point, the staff member called the youth a “bad ass bastard” and told the youth that he would die while incarcerated. The staff member walked over to the youth and slapped a cup out of his hand. In the process, the staff member struck the youth in the face. Other staff approached and restrained the staff member. The staff member attempted to break free and attack the youth. Security staff arrived on the unit and placed the staff member in another room where she proceeded to curse, pace, and verbally threaten to harm the youth. Security staff reported that the staff member called the youth a “bitch ass nigger” and challenged him to “do something or shut up.” An OCA investigation confirmed abuse by the female staff member. She resigned her position in lieu of termination.

- On November 9, 2003, staff E.V. grabbed youth B.G. by the wrist and threw him to the floor after youth B.G. refused a direct order. The youth suffered swelling and redness to the temple area. The OCA investigation confirmed that the staff member used excessive force and that the youth did not pose a risk to anyone at the time that force was used. We requested but were not provided documentation regarding any discipline or corrective action taken by the State following this incident.

- On May 10, 2003, youth C.P. repeatedly requested a snack from staff T.B. Staff T.B. became angry and lunged at youth C.P., pushing the youth backwards towards the kitchen door. Staff T.B. then picked up youth C.P. and tried to throw him over his shoulder. Staff T.B. and youth C.P. fell to

the floor where staff T.B. struck youth C.P. in the head and ribs. Staff M.Q. responded to the altercation and made repeated attempts to strike youth C.P. with his forearm. At the same time, staff T.B. exerted pressure to youth C.P.'s throat. Security staff arrived and attempted to intervene. Staff T.B. and staff M.Q. pushed security staff away and continued to try to fight youth C.P. even though youth C.P. was not fighting back. At one point, staff M.Q. attempted to strike youth C.P. but, instead, hit security staff K.O. in the jaw. An OCA investigation confirmed abuse by staff M.Q. and staff T.B. Staff D.O. resigned in lieu of termination and Rader terminated the employment of staff T.B.

III. REMEDIAL MEASURES

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

1. Ensure that youth are adequately protected from inappropriate sexual interaction with staff and other youth.

2. Ensure that youth are adequately protected from physical violence committed by staff and other youth.

3. Ensure that there are sufficient, adequately trained staff to safely supervise youth.

4. Ensure that staff are adequately trained in safe restraint practices and that restraints are used only in appropriate circumstances.

5. Ensure that staff adequately and promptly report incidents of violence and misconduct.

6. Ensure that all incidents of violence, use of force, or serious injury are adequately investigated and that appropriate personnel actions are taken in response to substantiated findings.

7. Develop and implement adequate policies and procedures to ensure that youth who are at risk of suicide and youth who are at risk of engaging in self-injurious behavior are properly identified, supervised, and treated.

8. Develop and implement adequate policies and procedures to ensure that medication is safely distributed and administered to youth.

9. Develop and implement adequate policies and procedures to prevent the introduction of contraband into the facility.

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I invite the State to discuss with us the remedial recommendations, with the goal of remedying the identified deficiencies without resort to litigation. In the event that we are unable to reach a resolution regarding our concerns, the Attorney General is empowered to institute a lawsuit pursuant to CRIPA to correct deficiencies of the kind identified in this letter, 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1).

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

Sincerely,

/s/ R. Alexander Acosta

R. Alexander Acosta
Assistant Attorney General

cc: The Honorable Drew Edmondson
Oklahoma Attorney General
Office of the Oklahoma Attorney General

Charles N. Nobles
Chairman
Board of Juvenile Affairs

Richard DeLaughter
Executive Director
Office of Juvenile Affairs

Jimmy Martin
Superintendent
L.E. Rader Center

The Honorable David E. O'Meilia
United States Attorney
Northern District of Oklahoma