U.S. Department of Justice

Civil Rights Division

Assistant Attorney General
950 Pennsylvania Avenue, NW - RFK
Washington, DC 20530

March 15, 2007

The Honorable Rick Perry
Governor of Texas
P.O. Box 12428
Austin, Texas 78711-2428

Re: Evins Regional Juvenile Center, Edinburg, Texas

Dear Governor Perry:

I write to report the findings of the Civil Rights Division's investigation of conditions at the Evins Regional Juvenile Center ("Evins"). On June 9, 2006, we notified you of our intent to conduct an investigation of Evins 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.

On September 12-15, 2006, we conducted an on-site inspection at Evins with an expert consultant in juvenile justice. We interviewed staff, youth residents, teachers, school administrators, and administrative staff. Before, during, and after our visits, we reviewed an extensive number of documents, including policies and procedures, incident reports, investigation reports, infirmary logs, medical records, grievances from youth residents, staff personnel files, internal quality assurance reports, unit logs, orientation materials, staff training materials, and school records. In keeping with our pledge of transparency and to provide technical assistance where appropriate regarding our investigatory findings, we conveyed our preliminary findings to facility and Texas Youth Commission (TYC) officials at the close of our on-site visit.

We commend the staff at Evins for their helpful and professional conduct throughout the course of the investigation.

We received full cooperation with our investigation and appreciate the State's receptiveness to our consultant's on-site recommendations.

Consistent with the statutory requirements of CRIPA, we now write to advise you of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to address the deficiencies we have identified. 42 § U.S.C. 1997b. As described more fully below, we conclude that certain conditions at Evins violate the constitutional rights of the youth residents. In particular, we find that children confined at Evins are not adequately protected from harm.

Notwithstanding the foregoing, we are pleased to report that many of the youths that we interviewed at Evins had favorable things to say about specific staff members and indicated that these individuals carried out their job responsibilities in a professional and fair manner. In addition, our investigation found that in many instances, Evins has taken strong disciplinary action, including termination of employment, against employees who use inappropriate force techniques.

I. BACKGROUND

The State of Texas, through TYC, owns and operates the Evins Regional Juvenile Center, located in Edinburg, Texas. Evins houses male juveniles who have been adjudicated delinquent by the Texas juvenile courts and committed to TYC care. Evins originally opened in 1994 as a 48 bed unit. However, Evins expanded to 240 beds–-its present capacity–-in 1997. Evins houses youths who are typically between the ages of 15 and 20.

Evins houses youths in several manners. First, the original two housing units, known as "Building 1" and "Building 2," have 24 individual sleeping rooms that are divided into 12 room pods with a day room (i.e., common living area) in each pod. Building 1 houses youths in Evins' chemical dependency treatment program, while Building 2 houses youths on psychotropic medications and youths who are too young to be placed in the general population. Second, the two newer housing units, known as "Building 3" and "Building 4" are open bay dormitory styled constructions. Each building is divided into four 24 bed pods that have no individual rooms. Each of these buildings contains a security station in the middle of each pod.

The Evins campus also contains an administration building, two school buildings, a medical/social services office, a dining

hall, a vocational building, a security building, a staff training building, and a maintenance shop.

II. LEGAL STANDARDS

The Eighth Amendment requires that a state provide detainees with basic human needs, including protection from harm. Hare v. City of Corinth, 135 F.3d 320, 324 (5th Cir. 1998) (citing Farmer v. Brennan, 511 U.S. 825, 832 (1994)). In Morales v. Turman, the U.S. District Court for the Eastern District of Texas made clear that physical abuse of juveniles was intolerable under the Constitution. 364 F. Supp. 166, 173 (E.D. Tex. 1973) See also Bright v. Hickman, 96 F. Supp. 2d. 572, 576–77 (E.D. Tex. 2000).

Additionally, corrections officers have a duty to protect inmates from violence at the hands of other inmates. Farmer, 511 U.S. at 833. Officials violate the Constitution when they act "with 'conscious or callous indifference' to their duty to protect [a] prisoner from others." Hare, 135 F.3d at 327 (quoting Johnston v. Lucas, 786 F.2d 1254, 1260 (5th Cir. 1986)). Corrections officials may be constitutionally liable when they "have failed to control or separate prisoners who endanger the physical safety of other prisoners and the level of violence has become so high . . . it constitutes cruel and unusual punishment." Gullatte v. Potts, 654 F.2d 1007, 1012 (5th Cir. 1981) (citation omitted).

The Eighth Amendment's prohibition against cruel and unusual punishment forbids the unnecessary and wanton infliction of pain, which includes the unwarranted or excessive use of restraints. See Hope v. Pelzer, 536 U.S. 730, 737 (2002). Minimal constitutional standards require that physical restraints only be used when a youth is out of control and poses a serious danger to himself or others. See also Morales, 562 F.2d at 998 n.1 (incidences of prolonged isolation and unsupervised use of physical restraints could be adequately addressed under the Eighth Amendment).

III. FINDINGS

We find that Evins fails to adequately protect the youths in its care from youth and staff violence.

A. Youth Violence

Juveniles in institutions have a constitutional right to be reasonably safe from harm inflicted by other juveniles.

Facilities must maintain sufficient structure, safeguards, and staffing to ensure reasonable safety. Our investigation revealed an unacceptably high rate of youth violence at Evins. The atmosphere at Evins is chaotic and dangerous. Youths frequently fight with each other without detection or intervention by staff. Staff members and youths we interviewed consistently reported that staff members are unable to manage youths' behavior due to inadequate staffing. According to information provided by TYC, there were 1,025 reported youth-on-youth assaults at Evins in 2005, an average of 2.8 per day. For the first six months of 2006, there were 568 reported youth-on-youth assaults, an average of 3.1 per day. This frequency of assaults is a substantial departure from generally accepted professional standards. Nationally, facilities comparable to Evins typically report an average of .241 youth on youth assaults per 100 days of confinement which, for Evins, correlates to 1.235 assaults per 100 days of confinement.[1] Thus, the rate of assaults at Evins is approximately five times the national average.

While the number of youth-on-youth assaults at Evins is alarming, the actual number of youth assaults is likely even higher than what is reported. During our tour, youths consistently reported that there are numerous incidents of youth-on-youth violence about which staff are unaware. Although Evins has installed cameras to monitor the dormitories, youths are able to avoid being recorded by fighting in the cameras' blind spots. Residents reported that it is easy to arrange fights out of staff's line of sight during recreation by "catching the wall," which refers to a fight that occurs near a building but outside the vision of either staff or the security cameras. Youths we interviewed indicated that they plan fights in the bathrooms on the living units, which are also outside the range of the security cameras. In light of the high potential for undetected and unreported youth violence, the amount of violence is likely much higher than what the facility documents.

The following examples illustrate the serious nature of youth-on-youth assaults:

- On August 25, 2006, a youth assaulted another youth who was coming out of a meeting with his caseworker, striking him with closed fists on his back and head. The youths continued to strike each other with closed

[1]Data comparison based upon Performance-based Standards (PbS), a self-improvement and accountability system developed by the Council of Juvenile Correctional Administrators.

fists. The initiating youth escaped from an attempted physical restraint by a Juvenile Correctional Officer ("JCO") and grabbed a broom, which he started swinging at the other youth before staff were able to restrain him.

- On June 22, 2006, at least seven youths were involved in a riot in the cafeteria. Staff attempted several unsuccessful physical restraints and ultimately had to deploy pepper spray to subdue two youths.

- On May 27, 2006, one youth attacked another youth while they were in line to go to the cafeteria, punching him in the face and the back of the head. While staff were attempting to restrain the youths, one youth headbutted the other in the face, seriously injuring his jaw.

- On April 16, 2006, a youth was assaulted from behind by another youth, striking him with closed fists on his neck, shoulders, and face.

- On March 17, 2006, a staff member walked into a group room and witnessed a youth bleeding from his lip and crying. The youth initially refused to identify his assailant, but eventually did.

- On February 17, 2006, two youths were involved in a fight in their dorm. One staff member tried to intervene, and fell to the floor trying to execute a physical restraint. The staff member injured himself and was out of work for two months. In an Accident Review Board meeting on March 31, 2006, Evins staff assessed the situation, saying that in order to prevent reoccurrence, "We need to have less youths on pods, this is when we were over populated and short of coverage."

- On or about February 3, 2006, a youth requested to go to security because he was being assaulted by other youths. He reported that they were assaulting him because he would not let them take his food. He reported that another youth hit him with closed fists near his left eye and again on his right cheek. Security was called and the youth was taken to security.

- On June 26, 2005, a JCO unlocked the door to a group room and left it unsupervised. Two pairs of youths seized this opportunity to fight after they were left unsupervised. Although two staff were aware of this incident, neither reported the incident, documented the incident in any manner, or referred the youths involved.

Many of the youths we interviewed stated that fights are a regular part of the culture on the living units. Youths consistently reported that they did not feel safe. One said, "It's not safe for me to be on this campus." Another related, "In a gang you're not safe, but safer." Our investigation revealed that the unacceptable level of youth violence at Evins results from the following systemic deficiencies: inadequate staffing; inadequate programming; inadequate classification; and a dysfunctional grievance system.

1. Inadequate Staffing

The most striking factor contributing to the frequency of youth-on-youth violence is the absence of sufficient staff to adequately supervise youths at Evins. Without adequate numbers of trained staff on duty, it is not possible to respond in a safe and timely manner when violence and other crises occur. Moreover, without adequate numbers of qualified staff, correctional officers do not have the time to build the relationships with youths that are necessary to identify potential conflicts on their unit and prevent incidents from occurring.

The physical layout of Evins further exacerbates the current staffing deficiencies. Most assaults at Evins take place in Buildings 3 and 4, which are each broken into four pods each housing 24 youths in open bay dormitory style sleeping arrangements with the youths sleeping in bunk beds. In this open physical environment, it is difficult for staff to adequately supervise youths. Increasing the number of JCOs available to supervise youth would enable staff to be aware of early signs of trouble and to take measures to defuse problems before violence erupts. Moreover, additional JCOs are needed at the facility to provide shift relief. We found that Evins staff are extremely overworked because there are not a sufficient number of staff to cover shifts. Staff reported that they are frequently required to work double shifts of 16 hours, often without advance warning, leaving them tired, short-tempered and less alert. The high level of violence that we found at this facility is not surprising given these circumstances. One JCO said that staff

don’t have control of the units that they supervise and that the staff to youth ratio was not good. Another officer said that over the past two weeks he had worked about eight 12-hour shifts.

It is often the case at Evins that one staff member is left to oversee the entire pod of 24 youths. Youths and staff reported that, at times, one of the two staff in a Building may leave the area to perform other duties. Such absences place the youths – as well as staff – at significant risk of serious harm. Supervision is inadequate at night, as well. One youth reported that he has been assaulted at night by other youths on at least four separate occasions. The facility investigator confirmed that in each instance staff provided inadequate supervision.

We also found that there is inadequate staff to control movements between buildings on Evins’ sizable campus. Subsequent to our on-site tour, we were informed by TYC officials that on October 1, 2006, after dinner, 20 of the 24 youths from one dorm broke from their line and scattered around the campus. It apparently took staff hours before these 20 youths, and 4 others who left the cafeteria to join them, were brought under control. That same evening, several other youths from another dorm took advantage of the disorder, kicking open the exterior door from their pod and dispersing about Evins’ grounds. It took most of the night for staff to bring these youths under control. This event highlights ongoing concerns at Evins regarding the ability of staff to gather intelligence regarding security risks and to take sufficient measures to control youths’ behavior.

The safety concerns related to inadequate staffing noted above are exacerbated when the facility is over populated, as it was during our tour. While we were on site, we were told the facility’s population was 251 (its capacity is 240). Overpopulation at Evins extends the already stressed staffing beyond already unacceptable levels, and the logistical challenges of supervising youths in excess of the population maximum creates additional difficulties in properly maintaining order.

Our findings regarding the inadequate number of staff at Evins are not likely to surprise its staff or residents. Staff readily acknowledged to us that there are not enough of them to safely supervise the youths in their care. Several staff members opined candidly that Evins was inadequately staffed. One JCO stated, “We react, not prevent.” Several staff confirmed that they found it difficult to provide adequate supervision in the open bay dormitory style living units. One JCO commented, “[e]ven with two staff working the room, things can happen really fast. You can get distracted and something bad can happen.”

2. Inadequate Programming

Compounding the concerns with safe supervision of youths, we found that Evins does not provide youths with adequate programming or incentives to promote positive behavior. There is a behavior modification system, but it offers no incentive to the considerable percentage of the population that is facing long term confinement. As such, some residents have no incentive to conform their behavior to meet the requirements of the behavior modification system. Due to determinate sentences, these residents will not be able to shorten their time at the facility.

Another deficiency that both youths and staff mentioned is the lack of incentives for youths to behave appropriately. One JCO commented, “Kids need incentives. Kids need to be able to earn more privileges.” A resident said, “There’s nothing to do especially on weekends.” Another resident said he believed that boredom contributed to fights between residents. He said, “Kids get bored and they fight over little things. Little things just get out of hand.”

Evins’ large day rooms and open sleeping dormitories permit significant numbers of residents to congregate in largely unstructured settings, increasing the potential for serious problems to develop among the youths. Juveniles who are not engaged in structured activities are more likely to engage in horseplay which, if adequate staffing is not provided, has the potential to spiral into fighting, assaults and other dangerous activities.

3. Inadequate Classification

The absence of an adequate classification system negatively impacts the frequency of youth-on-youth assaults at Evins. Generally accepted professional standards require that youths be housed and supervised in accordance with their classification. Reliable classification systems take into consideration such information as a youth’s age, charged offense, history of violence and escape, gang membership or affiliation, health and mental health concerns, and institutional history.

By these measures, Evins does not have an adequate classification system. Unless a youth is especially young (12 individual rooms are reserved for such youths), in a chemical dependency program, or on psychotropic medication, housing unit assignments are largely a function of where there is an available bed. Staff do not separate violent and non-violent youths.

Youths are not classified by age or by the seriousness of their charged offenses.

Our interviews with direct care staff, youths, and other TYC employees confirmed that the above examples of youth violence are representative of recurrent problems at the facilities and are not aberrational. The recurrent nature of the incidents reflects a lack of appropriate staffing, training, supervision, and reporting at Evins. Significantly, incidents that come to light appear to be appropriately investigated, and often lead to disciplinary measures against involved staff. This is consistent with generally accepted practices and we commend Evins for these systems. Nevertheless, Evins fails to implement systemic measures to ensure that similar incidents do not recur.

4. Dysfunctional Grievance System

The dysfunctional grievance system at Evins also contributes to the State's failure to ensure a reasonably safe environment. An adequately functioning grievance system ensures that youth residents have an avenue for bringing serious allegations and other complaints to the administration's attention. It also provides an important tool in evaluating the culture at the facility, and alerting the administration about dangers and other problems in the facility's operations. Few of the youths we interviewed expressed any confidence in the system. One youth reported that he was sitting at a table writing a grievance when a staff member came by and took it away from him. One JCO said that responses to grievances are slow and as a result, animosity and resentment builds among the youths.

B. Staff-on-Youth Violence

Juveniles at Evins have a right to be free from unnecessary restraint and the use of excessive force. We were pleased to learn that in many instances Evins has taken appropriate disciplinary action, including termination of employment, against employees when an inappropriate use of force is identified. Additionally, some youths identified specific members of the corrections staff who they felt were fair and conscientious in executing their duties. These are admirable attributes for a juvenile facility. Nevertheless, our investigation revealed an unacceptably high degree of physical abuse of youths by staff at Evins. We also found a disturbing consistency in the youths' accounts of the use of unnecessary physical restraint and excessive force by many Evins' staff. The following examples are illustrative:

- On December 5, 2005 a resident alleged that a staff person slammed him to the ground and hit him. The resident was taken to the emergency room where he received eleven stitches. While there the resident had a mild seizure. TYC's internal investigation resulted in a finding of confirmed abuse and unprofessional conduct.

- On December 14, 2005 a resident showed a staff person large bruises on his chest. He said he had been attacked by gang members. TYC's internal investigation revealed that three staff had allowed the beating to continue and did not intervene on the victim's behalf. A finding of neglect was made on the three employees. Allegations against a fourth employee were not confirmed.

- On January 12, 2006 a resident alleged that a staff person hit him in the throat and hit his head several times against the wall. The youth had a large bump on his forehead and hurt his hand. The incident was confirmed by TYC officials as abuse.

- On January 15, 2006 a staff member allegedly pushed a resident, slammed him into a wall, threw him on a bunk and on the floor. The ensuing TYC investigation did not confirm abuse but did confirm an unnecessary use of force.

- On January 26, 2006 a resident alleged that during a restraint a staff person pushed the resident's eyes "back into his face." The ensuing TYC investigation confirmed abuse and noted that prohibited physical restraint techniques had been used.

Interviews with Evins staff indicate that inadequate staffing ratios contribute to the use of more force than necessary in many incidents of physical restraint. Virtually every correctional officer we interviewed expressed concern about maintaining control of the facility. As detailed above, we have found that this facility suffers from inadequate staffing, and that many of the staff at Evins have not been adequately trained nor do they have much practical experience on-the-job. When staff feel outnumbered and stretched too thin, they are more likely to apply extra force during a restraint to emphasize to the youth that non-compliant behavior will not be tolerated. These factors have a significant detrimental effect on the morale of Evins staff. One staff person summed it up by saying, "Staff

are tired. Working 12 hour shifts day after day. Morale is low."

Additionally, staff communicated to us that they do not feel appropriately trained. Many staff were critical of the training they receive on how to deal with non-compliant and aggressive youths. One JCO flatly stated, "Core training is a waste of time." Our staff interviews consistently revealed a sense of helplessness that greatly contributes to the low morale among those staff who have the most contact with the youths. Our investigation revealed that Evins is well behind in on-the-job training, partially because staff turnover is so high. One staff member said that the lack of training and turnover among JCO staff is the biggest problem the facility has. We note that the training concerns our investigation revealed closely mirror those identified by TYC as having contributed to the well-publicized October and November 2004 riots.[2] An internal monitoring review from the Director of Juvenile Corrections, dated December 13, 2004, noted that the JCO staff did not express confidence in their ability to perform their jobs. "Several of the JCO staff interviewed did not express confidence in their ability to perform the requirements of the job adequately." Elsewhere, the same report stated, "Several of the JCO staff interviewed did not know what verbal judo was because of the turnover in staff and the lack of training. They did not express confidence in their ability to conduct huddle ups and behavior groups."[3] Our investigation indicates that the facility still has large deficits in its training.

Related to the deficiencies in training, we also observed deficiencies in the way Evins staff document and review incidents. Our review revealed that incident reports filled out

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[2] Small gang-related race riots reportedly occurred on October 25, 2004 and October 28, 2004. The second riot, which reportedly took place in the cafeteria, began after two youths were allegedly stabbed by youths affiliated with a gang. According to the TYC, one youth was injured by other youths, while another youth injured himself when he broke a glass window.

[3] "Huddle ups" are short individual and small group talks that are administered when staff observe a situation that may evolve into an incident. Huddle ups are designed to defuse a situation before it escalates by helping youths learn how to appropriately handle a situation. "Behavior groups" are larger group sessions designed to assist youths properly conduct themselves in the general population.

by Evins staff frequently lack important information such as details of who was present during the incident, what happened during the incident, and what precipitated the incident. This occurs because, apparently, staff are reluctant to cooperate with Evins' investigator. In addition, at the time of our tour, Evins employed only one investigator for the entire facility. Given the number of residents at Evins, the high number of incidents, and the investigator's lack of institutional support and authority to compel staff statements/documents in a timely

It also appears that the process for reviewing the use of restraints is deficient. In most of the reviews we sampled, the reviewer did not evaluate the restraint at all, but simply noted that the incident report (IR) form was not filled out completely and correctly. Additionally, there appears to be a significant problem in obtaining copies of the security camera's video for use in the investigation process. According to the information technology staff, camera images are only held for 5 to 11 days before they are overwritten with new data. According to the investigator, in about two-thirds of the cases, the video of an incident has been deleted before he is able to secure a copy for his investigation.

We also note that the climate of violence at Evins also affects staff safety. Many of the staff we interviewed said they had been assaulted by residents. On March 31, 2006 Evins' Accident Review Board met and analyzed seven incidents that resulted in staff injuries between January 10 and February 24, 2006, four of which resulted in those staff missing work for at least three weeks. One of the incidents examined took place on February 17, 2006. Two residents were involved in an argument that escalated into an assault. A JCO attempted to intervene, injured his knee and back, and was off work for two months.

One JCO stated that he has been assaulted by youths on several occasions. During our on-site visit, another staff member showed us the scars from injuries he sustained when a youth wielding a shank stabbed him twice in the chest while the JCO was trying to break up a riot in the cafeteria on June 5, 2006. Another staff member we interviewed told us that a youth had punched him in the face and body, chipping one of his teeth.

IV. REMEDIAL MEASURES

In order to rectify the identified deficiencies and protect the constitutional and statutory rights of youths confined at Evins, this facility should implement, at a minimum, the following remedial measures:

1. Ensure that youths are adequately protected from physical violence from staff and other youths;

2. Ensure that there is sufficient, adequately trained staff to safely supervise the residents at all times;

3. Ensure that there is an adequate and appropriate behavior modification system in place;

4. Provide safe and appropriate housing for youths;

5. Develop and implement an adequate classification system to place youths appropriately and safely;

6. Develop and implement a grievance system that ensures resident access to a functional and responsive grievance process;

7. Develop and implement a use of force policy that provides clear guidelines and appropriate limits on the use of force;

8. Provide adequate training and supervision to correctional staff regarding safe and appropriate use of force and physical restraint;

9. Ensure that staff adequately and promptly report incidents.

* * *

Please note that this findings letter is a public document. It will be posted on the Civil Rights Division's website. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on the Civil Rights Division's website until ten calendar days from the date of this letter.

We hope to continue working with the County in an amicable and cooperative fashion to resolve our outstanding concerns regarding Evins. Assuming there is a spirit of cooperation from the State, TYC, and Evins, we also would be willing to send our

consultants' evaluations under separate cover. These reports are not public documents. Although the consultants' evaluations and work do not necessarily reflect the official conclusions of the Department of Justice, their observations, analysis, and recommendations provide further elaboration of the issues discussed in this letter and offer practical technical assistance in addressing them.

We are obligated to advise you that, in the entirely unexpected event that we are unable to reach a resolution regarding our concerns, the Attorney General may initiate 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 note that we are also authorized, pursuant to 42 U.S.C. § 14141, to initiate a suit to address the above described conditions.

We would prefer, however, to resolve this matter by working cooperatively with you and are confident that we will be able to do so in this case. The lawyers assigned to this investigation will be contacting the facility's attorney 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/ Wan J. Kim
Wan J. Kim
Assistant Attorney General

cc: The Honorable Greg Abbott
Attorney General
State of Texas

Edward Glenn Owens
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The Honorable Donald J. Degabrielle, Jr.
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