U.S. Department of Justice
Civil Rights Division

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

FEB 05 2020

The Honorable Henry McMaster
Governor of South Carolina
State House
1100 Gervais Street
Columbia, South Carolina 29201

Re: Notice Regarding Investigation of South Carolina Department of Juvenile Justice

Dear Governor McMaster:

We write to report the results of the investigation into the conditions of confinement in the Broad River Road Complex (BRRC), South Carolina Department of Juvenile Justice's (DJJ) long-term, juvenile commitment facility, conducted under the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997, the Violent Crime Control and Law Enforcement Act of 1994, 34 U.S.C. § 12601, and Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132. Consistent with the statutory requirements of CRIPA, we provide this Notice of the alleged conditions that we have reasonable cause to believe violate the Constitution. We also notify you of the supporting facts giving rise to, and the minimum remedial measures that we believe may remedy, those alleged conditions.

After carefully reviewing the evidence, we conclude that there is reasonable cause to believe that conditions at BRRC violate the Fourteenth Amendment to the Constitution and that these violations are pursuant to a pattern or practice of resistance to the full enjoyment of rights protected by the Fourteenth Amendment. Specifically, we have reasonable cause to believe that South Carolina fails to keep youth reasonably safe from youth-on-youth violence at the BRRC. Additionally, DJJ seriously harms youth by using punitive, prolonged isolation. The violations are exacerbated by the failure to train staff, implement effective behavior management tools, and establish key safety features in the physical plant at BRRC.[1]

---

[1] The Department opened its investigation to examine four issues: (1) whether DJJ fails to protect youth from youth-on-youth violence; (2) whether DJJ subjects youth to prolonged isolation; (3) whether DJJ fails to protect youth from physical abuse by staff; and (4) whether DJJ violates the Americans with Disabilities Act in its use of pre-sentencing residential evaluation centers. This Notice Letter applies to the first two issues. The Department's investigation into the third issue is ongoing. Our investigation of the fourth issue did not reveal a reasonable basis to believe that DJJ's use of secure evaluation centers violates the ADA.

We are obligated to advise you that 49 days after issuance of this Notice, the Attorney General may initiate a lawsuit under CRIPA to correct the alleged conditions we have identified if South Carolina officials have not satisfactorily addressed them. 42 U.S.C. § 1997b(a)(1). The Attorney General may also move to intervene in related private suits 15 days after issuance of this letter. 42 U.S.C. § 1997c(b)(1)(A).

We hope, however, to resolve this matter through a more cooperative approach and look forward to working with you to address the alleged violations of law we have identified. The lawyers assigned to this investigation will be contacting the DJJ to discuss this matter in further detail. Please also note that this Notice is a public document. It will be posted on the Civil Rights Division's website.

If you have any questions, please call Steven H. Rosenbaum, Chief of the Civil Rights Division's Special Litigation Section, at (202) 616-3244.

Sincerely,

Eric S. Dreiband
Assistant Attorney General
Civil Rights Division

cc: Alan Wilson
Attorney General
South Carolina

Clarence Davis
Counsel for the Department of Juvenile Justice
Griffin Davis Law Firm

Freddie Pough
Executive Director
Department of Juvenile Justice

Melody Lawson
Interim Facility Administrator
Broad River Road Complex
Department of Juvenile Justice

James Leventis
Deputy Civil Chief
District of South Carolina

INVESTIGATION OF SOUTH CAROLINA DEPARTMENT OF JUVENILE JUSTICE'S BROAD RIVER ROAD COMPLEX

United States Department of Justice
Civil Rights Division

United States Attorney's Office
District of South Carolina

February 5, 2020

TABLE OF CONTENTS

I. Summary

The United States Department of Justice provides notice, pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997b, that there is reasonable cause to believe, based on the totality of the conditions, practices, and incidents discovered there, that (1) the conditions at the Broad River Road Complex (BRRC), South Carolina's long-term, juvenile commitment facility, violate the Fourteenth Amendment, and (2) the violations are pursuant to a pattern or practice of resistance to the full enjoyment of rights protected by the Fourteenth Amendment. Specifically, the South Carolina Department of Juvenile Justice (DJJ) fails to keep youth reasonably safe from harm at the BRRC. DJJ, through its failure to train its staff, implement effective behavior management tools, and establish key safety features in its physical plant, seriously harms youth or places them at substantial risk of serious harm from other youth. Additionally, DJJ seriously harms youth by using isolation for punitive rather than legitimate purposes and by placing youth in isolation for lengthy periods. The Department continues to investigate allegations that youth are also at substantial risk of serious harm as a result of excessive force from staff.

We also conducted an investigation, pursuant to the Americans with Disabilities Act (ADA) of DJJ's decisions where it has the sole authority to determine whether to place youth with disabilities in its pre-sentencing residential evaluation centers, and whether DJJ reasonably modifies its pre-sentencing evaluation system to avoid disability-based discrimination. Our investigation of that claim did not reveal a reasonable basis to believe that DJJ's use of secure evaluation centers violates the ADA.

The Department does not serve as a tribunal authorized to make factual findings and legal conclusions binding on, or admissible in, any court, and nothing in this Notice should be construed as such. Accordingly, this Notice is not intended to be admissible evidence and does not create any legal rights or obligations.

II. Investigation

On September 27, 2017, the Department of Justice notified South Carolina of its intent to conduct this investigation. The Department conducted three onsite tours of BRRC and visited DJJ offices around the State. Department attorneys and expert consultants conducted interviews of dozens of staff members including both line staff and DJJ management. Department attorneys and consultants also interviewed youth confined or previously confined at BRRC, and their family members. Further, the Department inspected BRRC to learn about the physical plant. In addition to inspections and interviews, the Department reviewed thousands of documents. Finally, the Department reviewed video, to the extent it was available, related to allegations of abuse.

We appreciate DJJ's cooperation during the course of the investigation. Staff facilitated the visits and made themselves available for interviews. The agency also provided relevant

documents and materials before, during and after our visits. Recently, DJJ provided information about initial steps it is taking to respond to concerns that the Department raised on site. We look forward to working with DJJ to remedy the violations of law described below.

III. Background

DJJ is responsible for the "care and rehabilitation of children who are incarcerated" in the state. Indeed, the DJJ's stated mission is therapeutic: to "protect the public and reclaim juveniles through prevention, community programs, education, and rehabilitation services in the least restrictive environment." DJJ's rehabilitative services division operates five residential programs including the BRRC, a pretrial detention center, and three pre-disposition secure evaluation centers.

A. The BRRC Campus

The BRRC is located on a 540-acre sprawling campus in Columbia, South Carolina. On the grounds, there are three male dorms, an honor dorm, an isolation unit, an intensive treatment unit, and one female dorm. The three primary male dorms are identical: Each dorm has a central outdoor courtyard with three pods, or living areas, which extend from the courtyard. Each pod is a large room with bolted down chairs and tables in the middle, and 10 bed areas around the perimeter -- cinderblock cubicles that contain a bed and a nightstand. The female dorm is built to resemble a home with a kitchen, a living room with couches, and bedrooms shared by two female youths.

There are two housing units for youth who display behavior and safety issues: the crisis management unit (CMU or isolation) and the intensive treatment unit (ITU). The crisis management unit is BRRC's isolation unit, and it is intended to be used for youth who need to be temporarily removed from the general population if they violated the most serious level of behavioral standards and they are an immediate safety threat to either other young people, staff, or themselves, or are in danger of being harmed by staff, or young people. The CMU consists of three wings of concrete and steel cells. Each cell is 8 feet long by 8 feet wide and has no furniture except a cement bed and a thin mattress. The cells are dark: The only light comes from a solid metal door with a narrow slot at waist level and a small window that is painted over to prevent interaction with staff and youth outside. While confined, youth are completely isolated from the general population and confined to their cells for 23 hours a day. Youth in the CMU do not attend school, or participate in recreation or other programs with youth in the general population. Instead, youth receive educational worksheets to complete. Additionally, during the one hour outside of the cell, each youth is permitted to go outside for recreation but remains shackled in the small recreation area.

The ITU is a step-down unit for youth who are returning to the general population after placement in isolation. The unit houses up to six young people for two weeks at a time. The youth are housed in cells identical to those in the isolation unit, however, youth in the ITU are not confined to their cells all day. Young people in the ITU receive four hours of education each day with other ITU youth, and receive counseling, and mentoring services with other youth in the ITU.

B. The BRRC Population

Young people throughout the state who are 17 years of age or younger[1] and who are adjudicated delinquent may be incarcerated at BRRC. Between July 2015 and December 2017, the average age of youth at admission was 16 years old. The youngest child admitted during that period was 13 years old. The average length of stay was seven months, and the longest length of stay was two years and nine months. The average daily population of BRRC is slightly higher than 100 youth.

A large number of youth are sentenced to BRRC for nonviolent offenses. From July 1, 2015 through December 31, 2017, twenty-eight percent of all commitments to BRRC resulted from probation violations -- when a youth violates a condition of the terms of probation but is not charged with a new offense -- or contempt of court. These offenses are the most frequent reasons that youth were committed to BRRC.

BRRC's population includes youth with serious mental illnesses.[2] According to DJJ's agreement with the Department of Mental Health, DJJ is supposed to identify youth with serious mental illness and transfer these youth from BRRC to a psychiatric residential treatment facility. However, these youth spend a significant portion of their sentence at BRRC. In 2017, for instance, youth with serious mental illness whom DJJ eventually transferred to psychiatric residential treatment facilities remained at BRRC for an average of four months before transfer. Many youth with these conditions were never transferred to facilities designed to meet their mental health needs. In fact, of the 117 young people with serious mental illness who entered BRRC in 2017, around 75 of them were never transferred to a psychiatric residential treatment facility.

C. BRRC Staffing

Security staffing at BRRC has decreased by 27 percent over the past two years, from 235 in September 2017, to 172 in May 2019. This decrease occurred despite the population at

---

[1] South Carolina recently raised the age at which youth are considered to be a "child" or "juvenile" subject to the jurisdiction of the juvenile justice system. As of July 1, 2019, youth who are 17 years old and younger are considered juveniles in South Carolina. *See* S.C. Code Ann. § 63-19-20(1) (effective July 1, 2019). However, South Carolina exempts from the definition of "child" or "juvenile" any 17-year-old who is charged with a Class A, B, C or D felony, or any felony punishable by imprisonment for 15 years or more. *Id.*

[2] In an agreement between the South Carolina Department of Mental Health and DJJ, serious mental illness is defined as having one of the following DSM-5 diagnoses: 1) Psychotic disorders; 2) Major Depressive Disorder; 3) Bipolar Disorder; 4)Severe Attention Deficit/Hyperactivity Disorder; 5) Personality Disorder; 6) Persistent Depressive Disorder; 7) Post-Traumatic Stress Disorder; 8) Generalized Anxiety Disorder; 9) Obsessive Compulsive Disorder; 10) Anorexia Nervosa; Bulimia Nervosa; 11) Disruptive Mood Dysregulation Disorder. Agreement Between the South Carolina DJJ and the South Carolina Department of Mental Health for identification and transfer of DJJ Juveniles who have Mental Illness, Dec. 23, 2014.

BRRC increasing slightly, from 119 to 127.[3] During this period, there were no changes to the physical plant or program at BRRC that would justify this reduction in staffing.

D. Notice of Conditions at BRRC and DJJ's Inadequate Response

In the 1990's, a federal court issued an injunction requiring DJJ to implement minimally acceptable standards to remedy conditions of confinement at DJJ facilities that violated juveniles' constitutional and statutory rights. *See Bowers ex rel. Alexander S. v Boyd,* 876 F. Supp. 773 (D.S.C. 1995). DJJ developed and implemented a plan that resulted in the termination of the case in 2003.

Concerns about the safety of juveniles and staff, and the failure of DJJ to protect youth from harm, resurfaced in recent years after three large-scale incidents at BRRC resulted in youth sexual assaults, escapes from BRRC, and extensive damage to the dorms. Multiple State reports commissioned after the incidents put the State on notice of conditions at BRRC that endanger youth. Nonetheless, as described in detail below, the data reveal that there is an ongoing pattern of unconstitutional conditions at the facility.

IV. Conditions Identified

The Department's investigation has uncovered facts that provide reasonable cause to conclude that conditions at BRRC regularly and routinely violate the Constitution. In particular, the Department has reasonable cause to believe that DJJ, through its failure to train its staff, implement effective behavior management tools, and establish key safety features in its physical plant, seriously harms youth or places them at substantial risk of serious harm from other youth. Additionally, DJJ seriously harms youth by using isolation for punitive purposes and by placing youth in isolation for 23 hours a day in small, dark cells, without meaningful education or other programming.

As detailed below, the numerous, specific, and repeated violations of the Fourteenth Amendment at BRRC establish a pattern or practice of constitutional violations under CRIPA. To establish a pattern or practice of violations, the United States must prove "more than the mere occurrence of isolated or 'accidental' or sporadic discriminatory acts." *See Int'l Bhd. of Teamsters v. United States*, 431 U.S. 324, 336 (1977). It must "establish by a preponderance of the evidence that [violating federal law] was . . . the regular rather than the unusual practice." *Id. See also Equal Employment Opportunity Comm'n v. Am. Nat'l Bank*, 652 F.2d 1176, 1188 (4th Cir. 1981) (explaining that a "cumulation of evidence, including statistics, patterns, practices, general policies, or specific instances of discrimination" can be used to prove a pattern or practice).

[3] In September 2017, there were 119 youth incarcerated at BRRC. South Carolina DJJ, *SCDJJ Monthly Dashboard September 2017*, https://www.scstatehouse.gov/CommitteeInfo/HouseLegislativeOversightCommittee/AgencyWebpages/DJJ/Monthly%20Report%20-%20September%202017%20(pdf).pdf. As of June 24, 2019, there were 127 youth incarcerated.

A. DJJ Fails to Keep Youth Reasonably Safe from Harm at Broad River Road

We apply the United States Constitution's Fourteenth Amendment Due Process Clause standard in our analysis of conditions and use of isolation at BRCC. Under this standard, juvenile justice officials must ensure that detained youth are housed in reasonably safe conditions and protected from the aggression of others, whether "others" be juveniles or staff. *Alexander S.,* 876 F. Supp. at 797-98 (citing *Brooks ex rel. Thomas S. v. Flaherty,* 699 F. Supp. 1178, 1200 (W.D.N.C. 1988), *aff'd,* 902 F.2d 250 (4th Cir. 1990)). This is consistent with the standard the Supreme Court has applied to other populations being confined for non-punitive purposes. *Bell v. Wolfish,* 441 U.S. 520, 535 (1979) (adult pretrial detainees); *Youngberg v. Romeo*, 457 U.S. 307, 314-15 (1982) (people who are involuntarily committed due to disability). *Bell* requires courts to consider whether the "conditions amount to punishment of the detainee," and, if not, whether conditions are reasonably related to a legitimate government purpose and excessive relative to that purpose. *Bell,* 441 U.S. at 538-39. Courts must judge the "reasonableness" of the practice in question by looking at whether it departs from generally accepted professional standards. *Youngberg*, 437 U.S. at 315-16.

Adjudicated youth, like those confined at BRRC, have a liberty interest in personal safety and avoiding undue restraint. *See Blackmon v. Sutton*, 734 F.3d 1237, 1241 (10th Cir. 2013) (applying the *Bell* standard to case of a juvenile detainee); *A.J. v. Kierst*, 56 F.3d 849, 854 (8th Cir. 1995) (relying in part on the fact that the juvenile system "is rehabilitative, not penal in nature" to apply to the Fourteenth Amendment to a pretrial juvenile facility); *Gary H. v. Hegstrom*, 831 F.2d 1430, 1432 (9th Cir. 1987) (holding that Fourteenth Amendment applies to conditions in juvenile justice facilities because they are not criminal or penal); *Santana v. Collazo*, 793 F.2d 41, 43 (1st Cir. 1986) (*Santana II*) ("[J]uveniles who have not been convicted of crimes have 'a due process interest in freedom from unnecessary bodily restraint which entitles them to closer scrutiny of their conditions of confinement than that accorded convicted criminals.'"); *Hewett ex rel. H.C. v. Jarrard*, 786 F.2d 1080, 1085 (11th Cir. 1986) (applying the Fourteenth Amendment in a juvenile justice facility); *Alexander S.*, 876 F. Supp. at 797-98.

1. DJJ Fails to Keep Youth Reasonably Safe from Harm

The Department has reasonable cause to believe that, in the totality of the circumstances described below, DJJ has engaged in a pattern or practice of failing to keep youth reasonably safe from harm.

DJJ reported to the South Carolina legislature that, between July 2018 and May 2019, there were 134 fights and 71 assaults that resulted in 99 injuries to youth in a facility with an average daily population of just over 100. During this 11-month span, youth fights and assaults occurred, on average, on two out of every three days. On average, a youth sustained an injury every third day.

This data showing a pattern of frequent harm to youth is corroborated by our review of DJJ's documents. DJJs own incident reports, injury reports, videos, and data sets, demonstrate

that youth in DJJ custody are at substantial risk of physical harm. For example, several incident reports written by staff in 2017 describe significant incidents such as youth being punched, knocked to the ground and stomped, struck in the face, grabbed by the genitals, and having their glasses broken in altercations with their peers. Similarly, we reviewed injury reports identifying harms including loose teeth, a bite, and a broken nose. BRRC's own reports regularly document that youth are not reasonably safe from injury at the hands of their peers.[4]

The frequency of assaults on youth is high compared to assaults at other juvenile justice facilities. BRRC uses Performance-based Standards (PbS), a program designed to assist juvenile justice facilities across the country to track key metrics and identify problem areas, as indicated by red flags."[5] Facilities participating in the program receive reports comparing their performance on those metrics to the performance of their peers. Facilities receive a "red flag" for indicators on which their performance is at least 25% worse than the national average. PbS reports the State provided, including from the spring and fall of 2018, indicate that BRRC's performance was significantly worse than the national average for assaults on youth, injuries to youth by youth, and percent of youth who reported fearing for their safety within the previous six months. For example, BRRC received a red flag for number of injuries to youth by youth per 100 days of confinement. BRRC also received a red flag for the percentage of youth who were forced to engage in sexual activity within six months of the report.

Based on this evidence of regular assaults, fights, and injuries at BRRC, we conclude that youth at BRRC are not housed in reasonably safe conditions. *See Alexander S.,* 876 F. Supp. at 797-98; c*f. Youngberg,* 457 U.S. at 315-16 (recognizing the rights to be held in safe conditions and to be free from undue restraint).

One example of a youth whom DJJ failed to keep safe was A.B. During A.B.'s sentence at BRRC, he was the victim of repeated unaddressed harassment and attacks by other youth and staff. Throughout 2017, multiple incident reports and grievances indicate that A. B. did not feel safe at BRRC.

In one incident from November 2017, video showed an officer failing to protect A.B. from four attacks by groups of youth in his pod over three hours. The video shows groups of youth drag A.B. into a bedroom cubicle to assault him, twice chase him to the exit door of the pod and assault him and then finally assault him again in another bedroom cubicle. The officer responsible for maintaining safety on the unit, who was within sight and sound of the incidents, remained seated during two of the incidents. Despite being at close proximity to the incidents, the officer did not attempt to restrain the attackers from assaulting A.B., he did not remove A.B.

[4] Youth on youth harm in facilities often occurs when youth are idle. Filling youth schedules with rehabilitative activities reduces the opportunities for conflict to arise between youth who are restless and bored.

[5] The facility generates and tracks its own PbS data. The facility then enters it into a database so the information can be compared to data from other facilities participating in the program.

from the pod to protect him, and he did not call other officers to come to the pod to help assist in subduing the attackers.

Shortly after this incident, A.B.'s grandmother sent an email to DJJ. She complained that DJJ and its staff members had allowed A.B. to be "not only taunted, but beaten, hit, and have food thrown at him." She also said that when she visited him before the November incident, in June 2017, he could barely chew because he had been hit in the jaw. DJJ's response to A.B.'s fear was to place him in isolation for weeks[6] and return him to the same unit with instruction to stay near staff at all times. This response was insufficient to protect A.B. from harm and is an example of DJJ's inadequate response to juvenile assaults that contribute to a pattern of serious harm to youth.

The types of harms A.B. experienced at the hands of his peers were consistent with a number of reports by other youth and family members we interviewed and found credible.

2. Inadequate DJJ Facilities, Policies, and Practices Contribute to Harm to Youth and Place Youth at Risk of Harm

The BRRC campus has significant blind spots and areas not covered by video surveillance, and officers' ability to overcome the challenges posed by the campus' physical layout are impeded by BRRC's staffing configuration. In addition, BRRC fails to protect youth from harm by failing to conduct effective training.

(a) Inadequate Physical Plant Security Measures

BRRC's physical layout and inadequate safety features place youth at risk of harm from assaults by other youth. As previously described, each of the primary housing pods for boys at BRRC includes ten individual sleeping areas. One officer oversees ten youth in each male living pod, and each living pod within a dorm is physically secluded from other pods and from the control station. Officers in the male living pods must visually secure a large area, while simultaneously controlling the behavior of ten youths. As described below, this facility design and staffing leads to officers being unable to identify and intervene in youth-on-youth assaults.

BRRC staff do not have a line of sight to supervise youth in the two end pods in each housing unit or in the shower area. We identified multiple instances where youth harmed other youth in this supervision gap. For instance, an incident video showed several youth chasing another youth into the sleeping area on the farthest end of the pod. Apparently, the officer could not see that the youth were fighting because he did not intervene until all of the youth in the pod crowded around the area. Another incident video showed two youth following another youth into the shower area. The two youth assaulted the other youth in the shower area outside the video coverage while the officer remained in the pod. The officer did not reach the shower

[6] As discussed in Part IV.B., below, we concluded that DJJ's use of isolation violates youths' constitutional rights.

area to intervene until the youth's towel was filled with blood. The lack of a line of sight to supervise all youth, and the absence of an additional officer to assist in responding to incidents places youth at risk of harm. These incidents demonstrate that the physical layout of the pods makes it difficult for officers to respond promptly to an incident while supervising the pod. In addition, physical obstacles to providing adequate safety and supervision are exacerbated by BRRC's 1:10 staffing configuration in the male pods. Officers are working alone and when they need help, they have to summon colleagues to come from other pods to provide assistance. An officer whom we interviewed was visibly shaking while she explained how difficult it is to control ten youth without any other officers to provide support.

In addition, there are many locations on the campus that are not covered by video surveillance. These include areas outside the gymnasium, the courtyards that connect each housing pod, and the buses that transport the youth around campus. Dozens of use of force reports, for example, indicate that the reviewing officials were not able to conduct a full review of the incidents because video was unavailable. These reports confirm that BRRC leadership is aware of the limitations imposed by its video system.

BRRC's video retention practices are insufficient to ensure that, where an incident is recorded, the footage can be reviewed and appropriate action taken to prevent future harm. Investigation reports we reviewed often noted that video was not available due to the lapse in time. Similarly, when we sought video for 43 incidents that occurred in 2017 based on documents we received about those incidents, DJJ was only able to produce video of 12 incidents. According to DJJ practice, videos are only kept for two weeks, unless the incident is sent to the inspector general's office for an investigation. However, because of the short time before the videos are destroyed and the slow investigation process, many investigations indicate that the video was not available because of the time lapse. The failure to preserve video hampers the ability of the investigators to substantiate the allegations, and many of the investigation reports we reviewed deemed the allegation as unfounded because the investigator could not review the video evidence.

(b) Failure to Train

BRRC fails to take reasonable steps to prevent harm to youth, including conducting effective training. In order to prevent and respond to youth on youth harm, staff must be able to implement behavior management techniques including de-escalation and, where de-escalation fails, use approved restraint procedures. Use of force reports, which often described staff responses to youth fights, typically did not describe de-escalation efforts by staff.

The 2017 General Assembly Legislative Audit Council report, which examined harm caused by three large scale incidents in the facility, including through youth on youth assaults, determined that DJJ staff were "unfamiliar with basic security procedures." An audit by separate corrections consultants also recommended that DJJ implement annual Back to Basics refresher trainings for staff because interviews indicated that staff were uncertain about use of force and restraints. Consistent with these reports, not all staff we interviewed were able to clearly

describe the approved restraint procedures. Furthermore, video and use of force reports described restraints in which staff responded to youth on youth fights by using restraint techniques that were inconsistent with DJJ policy and generally accepted practice in the field of juvenile justice. For example, we reviewed a video in which an officer intervened in a fight between two youth by restraining a youth using a chokehold—not an approved technique.

In sum, the information gathered in our investigation indicates that staff are not effectively trained to manage youth behavior and prevent harm to youth.

B. DJJ's Use of Isolation Violates the Constitutional Rights of Youth at Broad River Road

The Department has reasonable cause to believe that DJJ engages in a pattern or practice of using isolation in the absence of a legitimate governmental objective in violation of the Due Process rights of youth at BRRC.

Under the Due Process Clause, isolation of young people can be justified where the placement is reasonably related to a "legitimate government objective". *Cf. Bell*, 441 U.S. at 535-39 (applying the Fourteenth Amendment to adult pretrial detainees and holding that restrictions on the liberty of an individual not convicted of a crime must be reasonably related to so legitimate government objective); *Santana I*, 714 F.2d at 1180, 1181-82 (applying *Bell* to young people incarcerated and placed in isolation). Restrictions that do not relate to a legitimate goal amount to punishment and are impermissible. *Bell*, 441 U.S. at 534-39. For example, isolation for minor misbehavior or for failing to follow facility rules did not offer a legitimate government objective to isolate. *See Williams ex rel. V.W. v. Conway*, 236 F. Supp.3d 554, 567, 582, 590 (N.D.N.Y. 2017) (denying motion to dismiss where plaintiffs alleged that they were isolated for minor misbehavior); *Pena v. N.Y. Div. for Youth*, 419 F. Supp. 203, 210 (S.D.N.Y 1976) (enjoining placement in isolation for punitive reasons).

Even if a facility isolates a youth for a legitimate reason, the conditions in which the facility isolates the youth may be sufficiently excessive or harsh to overcome the legitimate objective and amount to punishment. *Cf. Bell,* 441 U.S. at 539 n.20 (advising that even where there are legitimate objectives offered, some conditions of confinement, for example "loading a detainee with chains and shackles and throwing him in a dungeon" are so harsh that there could no other purpose than to punish). For example, use of isolation to protect youth from harm and long-term isolation may be unconstitutional if the period of isolation or the conditions of isolation are excessive. *R.G. v. Koller*, 415 F. Supp. 2d 1129, 1148-49, 1154-55 (D. Haw. 2006) (protection from harm); *Santana I*, 714 F.2d at 1181-82 (long-term isolation).

1. DJJ Isolates Youth for Punishment

The Constitution forbids isolating youth solely for punishment. DJJ uses isolation to punish youth. Though its policy expressly prohibits disciplinary isolation, our review of data and documents revealed that DJJ isolates youth frequently as punishment for minor misbehaviors when the youth was not a threat to health or safety.

According to DJJ policy, when officers isolate youth for behavior offenses, they may only isolate youth for Level 3 offenses such as fights with injuries and large group disturbances that pose serious threats to safety. However, the reports we reviewed revealed that a large number of youth were isolated for minor misbehaviors that posed no threat to safety and did not rise to a level 3 offense, meaning youth were being isolated for conduct that does not create a risk of harm to the youth or others. These offenses include behaviors such as showing disrespect, not complying with officers' directions, or using profanity towards officers. Some youth were put in isolation for masturbating in their beds or exposing themselves to officers, even though these incidents were non-violent and did not involve any physical contact or altercation with other youth or staff. Some particularly egregious examples of isolation for non-violent offenses included a youth who was placed in isolation for having playing cards, a youth who was isolated for being unable to urinate to complete a drug test, and two youths who were isolated for tattooing each other with ink pens. Similarly, a list of isolation placements for 2018 shows that a number of youth were in isolation for being "out of place," the term DJJ uses when a youth is not in his or her assigned housing or programming area.

These punitive placements go almost unaddressed by DJJ leadership. We reviewed hundreds of requests from 2015-2017 to place youth in isolation beyond four hours that were not reviewed for months after the request was made. Despite its stated policy objectives to protect health and safety, DJJ instead uses isolation mainly as a tool to punish youth and to enforce compliance with its rules.

Moreover, BRRC has consistently received red flags in its PbS reports for its use of isolation. In each PbS report that we received from DJJ (October 2015 through October 2018), BRRC received red flags for: 1) average duration of isolation/room confinement in hours; 2) percent of isolation terminated in four hours or less; and 3) percent of isolation terminated in eight hours or less.

2. DJJ Isolates Youth for Unreasonably Prolonged Stays in Inadequate Conditions

Youth at BRRC are isolated frequently and for significantly long stays. In 2017, DJJ isolated 232 youth at least once. While the average length of stay for a single CMU placement in 2017 was 3 days, DJJ isolated youth for 10 or more days 39 times in 2017. This included C.D. who was isolated for 34 days for a "fight without injury" and E.F. who was isolated for 27 days until he could be "staffed in ITU." [7] The longest single stay in isolation in 2017 extended to 225 days.

[7] We learned in our investigation that many youth cycle from CMU to ITU many times. On our visit to the ITU all of the youth who were confined there had previously been through the program at least one time and had returned, indicating that the interventions offered at the ITU the first time were not successful.

Many youth housed at BRRC during the two years covered by our document review (2015-2017) were isolated repeatedly, and thus spent a significant portion of those two years confined in isolation. While in isolation, these youth were segregated completely from other youth, denied meaningful education services, and forced to spend 23 hours a day alone without any contact with youth or staff. Below, is a chart of six youth who spent the most days isolated between 2015 through 2017:

Youth Name	Number of times isolated	Time span from first isolation in 2015 through last isolation in 2017	Total days isolated	Percent of time isolated
G.H.	24	9/14/15-2/24/17	301 days	57%
I.J.	20	7/26/15-3/15/17	276 days	47%
K.L.	11	9/17/15-4/16/17	231 days	40%
M.N.	22	9/10/15-4/10/17	206 days	36 %
O.P.	19	9/15/15-11/2/17	170 days	22 %
Q.R.	24	10/21/15-3/3/17	141 days	28%

DJJ continues to use isolation frequently and for long periods. DJJ reported to the South Carolina legislature that between July 1, 2018 and May 31, 2019, it used isolation 1044 times at BRRC – an average of approximately 94 times each month.[8] From January 1 to June 7, 2019, DJJ data indicated that there were 340 instances of youth isolation. One youth, B.B, had been in isolation for a total of 49 days as of June 7, 2019 for "mental health observation" and "refusal to exist on the unit."

The failure of DJJ to establish alternatives to placement for youth who need protective custody, who are suicidal, or who are self-harming also contributes to the unconstitutional use of isolation. From 2015 through 2017, there were 26 instances of isolation used for protective custody. Some youth were placed in isolation for protective custody many times. A.B., the youth whose assaults we described on page 7, was placed in isolation for protective custody 4 times for a total of 38 days from March 2017 to November 2017. There were 46 instances of youth placed in isolation under suicide watch (23 youth) or mental health observation (23 youth)

[8] *SCDJJ Monthly Dashboard May 2019.*

from 2015-2017. The longest CMU mental health observation placement in the data we reviewed was 11 days.

Additionally, while DJJ appropriately requires staff to justify continued isolation beyond four hours, DJJ improperly prolongs isolation in violation of the Constitution. Instead of observing a youth's behavior while the youth is in isolation and then deciding whether to extend the placement, officers admitted that they complete a form seeking an extension at the same time that the youth is sent to isolation. The forms we reviewed supported this assertion; the justifications for the extension for isolation always referenced the behavior exhibited by the youth that landed the youth in isolation, not current behavior that showed that the youth remained a threat to safety four hours after the original incident.

In isolation, youth are alone in their 8 foot long by 8 foot wide cell for 23 hours a day. Their cells are dark with no natural light—DJJ painted over the only windows in the cell to impede the youth from interacting with other youth and staff outside. Everything in the room is made of concrete and steel; steel doors provide entrance in and out of the cell and the door only has a slot for the officer to slide a tray of food to the youth and to communicate with them. There is a steel toilet and sink for plumbing and a bed frame made of poured concrete with a thin mattress on top.[9] The youth also receive no meaningful educational services or recreation and very little contact with staff members.

3. Youth Resort to Self-Harm and Suffer Worsening Mental Health

We reviewed medical records of youth who, while in isolation, displayed deteriorating mental health conditions attributable to the unreasonable length and conditions of confinement in isolation. Several of these youth displayed suicidal ideations. At least three youths tried to hang themselves while in isolation. The youth tied sheets around their necks. And even though the officers are supposed to perform regular safety checks every fifteen minutes on youth in isolation, one youth was able to keep the sheet tied around his neck for five minutes before the officers found him. None of these youth were provided appropriate psychiatric treatment—each youth was instead placed in a suicide resistant isolation cell where it is possible that the youth suffered further psychological harm.

Several youth reported being anxious, depressed, and attempting self-harming behaviors. We reviewed the medical records of S.T., a youth who was placed in avoidable and prolonged isolation for 13 days under suicide watch. While in isolation, his condition worsened. The nurse wrote that the youth appeared "sad, gave poor eye contact" and "reported suicidal ideations and having a plan of self-harm." Yet, DJJ did not provide this youth with any additional intervention and did not provide psychiatric care. Instead, the youth was returned to the suicide watch cell where he remained for six days until he signed a contract agreeing not to harm himself. Making

[9] Youth in the suicide-resistant cells have even less furniture. These cells have no sink, bathroom, or bed. The youth receive blankets and must sleep on the floor in a suicide smock.

a suicidal youth remain in isolation for six days until he signed a document promising not to hurt himself placed him at serious risk of harm.

We interviewed U.V., who told us that she cut herself while she was in isolation. She told us that being in isolation made her depressed and led to her cutting behaviors. According to her medical reports, she was admitted to the infirmary because she cut her arm after an officer told her "she was not loved, and would not leave lock up for three weeks." Instead of referring her to a staff psychologist at DJJ, or transferring her to a psychiatric hospital, the medical staff dressed the wound and sent her back to isolation for five days, where she remained at serious risk of harm.

We also interviewed W.X., a youth who was sentenced to DJJ from April 2014 through July 2017. He told us that he has AD/HD, schizophrenia and bipolar disorder. While he was at DJJ, he was isolated at least 19 times for 71 total days.[10] W.X. says that isolation affected him mentally. During one three-week stay, he says that he "started going insane": he could not stay calm or stop panicking. During this period, the officers did not let him out for recreation at all. When W.X. asked the officers to release him from his isolation cell due to his anxiety, they refused.

During our interviews, the Facility Administrator acknowledged that the best response for youth who attempt suicide or display suicidal ideations is to transfer these youth to a psychiatric hospital where the youth can receive intensive mental health treatment. However, as mentioned above, DJJ does not attempt to place suicidal youth outside of the facility because many psychiatric hospitals will not accept youth who have a history of delinquent conduct.

In sum, DJJ's use of isolation harms children and violates their constitutional rights to due process.

V. REMEDIAL MEASURES

DJJ should implement the following remedial measures to correct the violations identified in this report.

1. Improve the physical plant to ensure adequate surveillance and retain video that will enable facility leadership to investigate allegations of abuse.

2. Conduct a staffing study to determine the appropriate staffing levels and staffing patterns to adequately supervise youth in the male living units, and make changes to staffing patterns as necessary.

3. Train staff on positive behavior management tools and de-escalation to reduce youth on youth violence and the use of isolation as a response to youth behavior.

[10] We requested and received records verifying this claim. However, because we only requested isolation placements from January 2015 through December 2017, it is possible that he was isolated in 2014 as well.

4. Eliminate the use of isolation for minor misbehavior, protective custody, and mental health observation.

5. Replace long-term isolation with a short-term cool-down room in each housing unit for youth who are a threat to safety. Develop policies to ensure that youth who are placed in the cool-down room are returned to the general population as soon as they are no longer a threat to safety.

6. Develop admissions screening protocols to identify youth who are vulnerable to victimization by other youth in the facility. Create a specialized housing unit for these youth with access to equal recreational and educational services as youth in the general population.

7. Develop agreements with the Department of Mental Health to ensure the prompt transfer of suicidal youth to appropriate placements for mental health treatment.

VI. CONCLUSION

As stated above, we have reasonable cause to believe that the South Carolina Department of Juvenile Justice violates the constitutional rights of youth in its care, resulting in serious harm and placing them at substantial risk of serious harm. Specifically, we conclude that DJJ, through its failure to train its staff, implement effective behavior management tools, and establish key safety features in its physical plant, seriously harms youth or places them at substantial risk of serious harm from other youth. Additionally, DJJ seriously harms youth by using isolation for punitive rather than legitimate purposes.

We look forward to working cooperatively with South Carolina to remedy these violations.