OFFICE OF

STATE INSPECTOR GENERAL

Stephen B. Street, Jr., Inspector General

Ware Center for Youth

April 25, 2024

OIG CASE NUMBER: 23-0020-I

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JEFF LANDRY
GOVERNOR

STEPHEN B. STREET, JR.
STATE INSPECTOR GENERAL

State of Louisiana

Office of the Governor
Office of State Inspector General

April 25, 2024

Honorable Jeff Landry
Governor of the State of Louisiana
PO. Box 94994
Baton Rouge, LA 70804-9004

Re: OIG Case Number 23-0020-I (Ware Youth Center)

Dear Governor Landry:

The attached report details our investigation into the Ware Youth Center (WYC) and its contract with the Office of Juvenile Justice (OJJ) to provide secure care detention facilities and staffing for post-adjudicatory juveniles placed in OJJ's custody. The investigation was conducted at the request of the Office of the Governor by letter dated November 3, 2022.

A letter from Ware Executive Director Staci Scott is included in the report as Appendix A.

Respectfully Submitted,

Stephen B. Street, Jr., C.I.G.
Louisiana State Inspector General

SBS/ss
Attachment

JEFF LANDRY
GOVERNOR

STEPHEN B. STREET, JR.
STATE INSPECTOR GENERAL

State of Louisiana

Office of the Governor
Office of State Inspector General

Case Number: 23-0020-I

Report Date: April 25, 2024

INVESTIGATIVE REPORT

The Office of State Inspector General (OIG) conducted an investigation of Ware Youth Center (Ware) in Red River Parish at the request of Governor John Bel Edwards. This request followed the publication of a news article alleging "repeated abuses, overlooked complaints and a surge in suicide attempts" at Ware.[1]

INTRODUCTION

The primary focus of OIG's investigation was to determine whether Ware is presently a safe and secure environment to house juveniles who have entered Louisiana's juvenile justice system. Over the course of its investigation, OIG investigators visited Ware on nine different occasions, both scheduled and unannounced. OIG investigators also reviewed thousands of pages of records, including Critical Incident Reports spanning the five-year period from 2018 to 2022, records of state and local agencies, video footage, and other relevant materials. OIG investigators also met with and interviewed 45 individuals, including current and former juvenile residents and staff at Ware, state and local officials, and family members of former juvenile residents.

OIG conducted its own independent review of un-redacted records pursuant to its authority under La. R.S. 49:220.24 and 220.25.

At all times, Ware's leadership and staff were thoroughly cooperative and provided unrestricted access to their juvenile residents, staff, records and facilities.

[1] Dying Inside: Chaos and Cruelty in Louisiana Juvenile Detention; *New York Times,* October 30, 2022.

In summary, OIG's review of "critical incidents" at Ware over the five-year period determined that a small number of juveniles were responsible for a large percentage of reported incidents. Notably, OIG determined the following with regard to reported incidents at Ware:

- The five highest offending juveniles were involved in an average of 42 incidents each. These five repeat offenders were responsible for 164 of the 504 reported incidents (33%).

- 23 juveniles were involved in 10 or more incidents each. These 23 repeat offenders were responsible for 300 of the 504 reported incidents (60%).

- There was a marked increase in reported incidents in 2020 and 2021, which coincides with the time that nine of these high-offending juveniles arrived at Ware.

With regard to suicide attempts:

- 40% of suicide attempts at Ware from 2018 to 2022 involved the same five juveniles.

- 68% of suicide attempts at Ware from 2018 to 2022 involved the same 10 juveniles.

With regard to "elopements" (escapes):

- Of 114 reported elopements, 86% involved juveniles who were outside of their authorized areas, but remained on the Ware property. The remaining 14% were actual escapes where juveniles left the Ware property and were later apprehended by law enforcement.

- 52% of reported elopements involved the same 5 juveniles.

- 70% of reported elopements involved the same 10 juveniles.

OIG also conducted a detailed review of three juvenile suicides that occurred at Ware in 2017 and 2019, and the actions and events that followed.

OIG also reviewed Ware's reporting under the **Prison Rape Elimination Act** (PREA) over the same time period.

The details of OIG's investigation are related below.

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BACKGROUND

OIG Jurisdiction

The Office of State Inspector General (OIG) is authorized to examine and investigate the management and affairs of all departments, offices, agencies, boards, commissions, task forces, authorities and divisions of the executive branch of state government ("covered agencies") concerning waste, inefficiencies, mismanagement, misconduct, abuse, fraud, and corruption, and to conduct all necessary investigations into the same. OIG's authority to investigate extends to contractors and subcontractors of covered agencies. The Department of Children and Family Services (DCFS) and the Office of Juvenile Justice (OJJ) are both covered agencies.

Ware Youth Center Authority

In 1986 the legislature enacted La. R.S. 15:1097 through 1097.5, establishing the Ware Youth Center Authority as a political subdivision of the state with a territorial jurisdiction that included several North Louisiana parishes. [Act 833 of the 1986 Regular Session].

The authority is governed by a board of commissioners which is authorized to "enter into contracts for the management, administration and operation of a juvenile detention facility or facilities, shelter care facility or facilities, or such other juvenile justice facilities as are useful, necessary, expedient or convenient to carry out the plans and purposes of the commission."

The authority is funded, in part, by the assessment of special costs (1) against every defendant who is convicted after trial or who enters a plea of guilty in all felony and misdemeanor prosecutions in the district, parish and city courts of the parishes that

make up the authority; and (2) against every juvenile who is found to have committed a traffic violation or who is adjudicated a delinquent in all courts exercising juvenile jurisdiction in the same parishes.

Participating parishes include Red River, Natchitoches, DeSoto, Sabine and Webster. The authority also contracts with the Bossier Parish Police Jury.

History

Ware Youth Center is located on 115 acres on U.S. Highway 71 near Coushatta, Louisiana.[2]

Ware opened in 1993 as a juvenile detention facility for pre-adjudicated juveniles who are awaiting court proceedings in delinquency cases. At opening, the facility had beds for 18 juveniles. Additional construction completed in 1996 increased the juvenile detention facility's capacity to 32, where it remains today. The facility includes four areas called dayrooms, each one separate from the others and housing up to eight juveniles. One dayroom is for females.

Juvenile detention facilities are locally run, short term secure facilities that provide temporary safe and secure custody of youth during the pendency of juvenile proceedings when detention is the least restrictive alternative available to secure the appearance of the youth in court or to protect the safety of the juvenile or the public. [La. R.S. 15:1110; LAC 67:V.7505]. They may be owned and operated by any governmental, profit, nonprofit, private or public agency. Juveniles in detention include:[3]

- Youth arrested for delinquent acts
- Youth adjudicated delinquent and pending disposition
- Youth adjudicated delinquent and placed in the custody of the State of Louisiana and pending placement
- Youth detained by court order due to bench warrants or violation of court order

[2] An aerial view of Ware has been attached as Exhibit A.

[3] The Louisiana Children's Code, as amended effective April 19, 2024, provides, in pertinent part, that *child* means any person who commits a delinquent act before attaining seventeen years of age. [La. Ch. C. art. 804(1)(a)]. A *delinquent act* is an act committed by a child of 10 years of age or older, which if committed by an adult is designated an offense under the statutes or ordinances of this state.

In 1999 Ware opened a residential facility (group home) consisting of two cottages with twelve beds each for a total capacity of 24. Each of these cottages has three bedrooms with four beds in each. Construction of additional smaller cottages with six beds each brought capacity to 36 with two cottages now being used for juveniles who have been identified as in need of residential substance abuse treatment.

In 2009 Ware opened an intensive residential secure care facility for female juveniles who had been adjudicated delinquent by a judge and placed in the custody of OJJ. The facility consists of three cottages, each with a capacity of eight for a total of 24 beds. Ware entered into a series of one-year contracts with OJJ that continued through September 2023 when OJJ elected not to renew the contract, a decision that, according to OJJ, was "strictly a financial decision."[4] Sixteen juvenile females were then moved by OJJ from Ware to a facility in St. Martin Parish which when opened by OJJ in 2021 was intended, according to an OJJ spokesperson, to be a "transitional treatment unit" for males who had "demonstrated an inability or unwillingness to discontinue violent and aggressive acts."[5] The facility had previously served as a regional juvenile detention facility for pre-adjudicated juveniles.

Each facility – juvenile detention, residential home cottages, and intensive residential (secure care) – has its own multi-purpose building that includes classrooms, a kitchen and dining area and a gymnasium.

Licensing of Juvenile Detention and Residential Facilities

Ware holds two licenses issued by DCFS – a juvenile detention facility license (#15596) and a residential home license (#6488).

Licensing of residential homes by DCFS is required by La. R.S. 46:1401 through 46:1430. Applicable regulations are found at LAC 67:V.7101-7124. Ware's residential facility has been licensed since 1999.

Licensing of juvenile detention facilities became state law in 2010. Act 863 of the 2010 Regular Session, amending La. R.S. 15:1110, required DCFS to develop and

[4] OJJ Deputy Secretary Curtis Nelson, testifying before the Task Force on Juvenile Justice Facility Standards on October 4, 2023, stated "the recent move of the girls from Ware, that is all financial . . . unfortunately, we were not able to find the funding to continue our contractual relationship with the girls in secure care."

[5] OJJ spokesperson Beth Touchet-Morgan quoted in "No Light. No Nothing." Inside Louisiana's Harshest Juvenile Lockup; *Marshall Project*, *NBC News and* ProPublica, March 10, 2022.

establish statewide standards for juvenile detention facilities and requires facilities to be licensed. Applicable regulations are found at LAC 67:V.7501-7525. As of July 1, 2013 all juvenile detention facilities in the state were licensed and inspected by DCFS. There are 13 such facilities in the state. State regulations require DCFS to conduct at least one unannounced inspection of each detention center annually to determine compliance with licensing standards.[6]

Ware Youth Center Leadership

Kenneth Loftin served as Executive Director from Ware's opening until his retirement in August of 2015.

Joey Cox became Executive Director on August 1, 2015, and served in that position until he retired in January 2021.

Upon Cox's retirement, Kenneth Loftin returned to Ware as interim Executive Director, and was named Chief Operating Officer in February 2022. He retired in October 2023.

The current Executive Director is Staci Scott, who was named Executive Director by the Ware Board on February 8, 2022.

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REPORTING OF CRITICAL INCIDENTS

State licensing regulations require a juvenile detention facility to report all "critical incidents." Examples include suspected abuse or neglect, death, attempted suicide, escape, sexual assault and serious injury requiring medical treatment. Such incidents must be reported to DCFS Licensing, a parent or legal guardian of the juvenile, the judge and defense counsel of record and, if appropriate, to law enforcement. [LAC 67:V.7511(I)]

Licensing regulations for residential homes require similar reporting of "critical and other incidents." [LAC 67:V.7111(D)] Examples include elopement or unexplained absence of a resident, injuries of unknown origin, attempted suicide, injury with

[6] Effective July 1, 2024 the licensing authority for juvenile detention facilities is transferred to the Office of Juvenile Justice pursuant to La. R.S. 15:1110.3 (enacted by Act 445 of the 2023 Regular Session).

substantial bodily harm while in seclusion or during use of personal restraint, and unplanned hospitalizations or emergency urgent care visits.

DCFS provides a Critical Incident Report form that is completed and submitted online. The form (Exhibit B) requires the reporter to categorize the incident as one of the following:

- Injury Sustained While in Seclusion or During Restraint
- Unplanned Hospitalization
- Suicide Attempt
- Elopement
- Unexplained Absence
- Other

OJJ has a similar policy that applies to all employees and contract personnel. It requires "reporting incidents or observation of events that may have an impact on any aspect of the operation" of OJJ or "which affects the accomplishment of the agency's mission and guiding principles." [Youth Services Policy Number A.1.14] The policy provides the following definition:

> Unusual Occurrence Report (UOR) – A document that must be completed by staff to report incidents or observation of events that may have an impact on any aspect of the agency. UOR forms shall be made available to all employees working all areas at all times. Employees must complete and submit a UOR prior to the end of their tour of duty on the day the incident was observed or comes to the employee's attention in any way. If a UOR form is not available, the employee must use any paper available to report the pertinent information. UORs may also be submitted by email.

OJJ's UOR form (Exhibit C) lists 30 categories of incidents which allows more accurate reporting and categorization of incidents than DCFS's reporting form. For example, the UOR form provides separate categories for Escape and Unauthorized Area as well as separate categories for Sexual Misconduct, Prison Rape Elimination Act (PREA) – staff/youth and PREA – youth/youth. When completed, the UOR is scanned and emailed to OJJ.

CRITICAL INCIDENTS AT WARE

OIG conducted its own independent review of un-redacted critical incident reports at Ware over the five-year period from 2018 to 2022. OIG obtained reports and data from both Ware and DCFS. Incidents from both sources were combined and checked for duplicate entries, which were removed. OIG's review revealed the following:

- There are no objective criteria for classifying critical incidents into categories, resulting in inconsistent reporting that varies depending upon the subjective interpretations of individual staff members.

- Ware reported 504 Critical Incidents to DCFS.

    - There were a total of 180 juveniles involved in critical incidents during this time. The review determined that a small number of juveniles were responsible for a large percentage of reported incidents.

    - The five highest offending juveniles were involved in an average of 42 incidents each. These five were responsible for 164 of the 504 reported incidents (33%).[7]

    - 23 juveniles were involved in 10 or more incidents each. These 23 were responsible for 300 of the 504 reported incidents (60%).

    - There was a marked increase in reported incidents in 2020 and 2021, which coincides with the time that nine of these high-offending juveniles arrived at Ware.

    - In contrast to the juveniles involved in multiple incidents, 103 of the 180 juveniles were involved in a single incident each.

[7] Incidents that involved multiple high-offending juveniles were reported as single incidents.

- OIG determined the following with regard to **Elopements (escapes)**:
    - Of 114 reported elopements, 86% involved juveniles who were outside of their authorized areas, but remained on the Ware property. The remaining 14% were actual escapes where juveniles left the Ware property and were later apprehended by law enforcement.
    - 52% of reported elopements involved the same 5 juveniles.
    - 70% of reported elopements involved the same 10 juveniles.
- With regard to reported **Suicide Attempts**:
    - Ware submitted 63 incident reports under the category of "Suicide Attempt."
        - 40% of suicide attempts involved the same five juveniles
        - 68% of suicide attempts involved the same 10 juveniles.
    - OIG determined that some of the incidents reported as suicide attempts should have been reported under other categories.
    - Representative examples of incidents reported as suicide attempts included:
        - A juvenile scratching herself with a staple;
        - A juvenile rubbing a pencil across her neck;
        - A juvenile scratching herself with a strip of Velcro from a smock; and
        - A juvenile on medication who was in an "irritable mood" and "distraught," but took no action toward self-harm or suicide.

- OIG also determined that 19 incidents reported under the category of "Other" and five reported under "Unplanned Hospitalization" could have been reported as suicide attempts, which would bring the actual total over the five-year period to 75.

- Representative examples of incidents that could have been reported as suicide attempts but were instead reported in other categories included:

  - A juvenile who tied a jacket around her neck and attempted to hang herself by attaching the other end to a restroom door hinge;

  - A juvenile who tied a sheet around her neck and attempted to hang herself by attaching the other end to a shower head;

  - A juvenile who drank two ounces of body spray, after which poison control was called and the juvenile was placed on suicide watch; and

  - A juvenile who locked herself in a medical room, broke into a medicine cabinet and took 450mg of Seroquel (a drug used to treat schizophrenia and bi-polar disorder) and 10 Benadryl (an allergy medication with a normal dosage of 1-2 tablets every 4-6 hours).

SUICIDES AT WARE

From 2017 to 2022, three suicide deaths[8] occurred at Ware. These are detailed below:

March 7, 2017 – 16 year old female

At approximately 8:00 pm on March 7, 2017, a 16 year-old female residing in cottage #3 of the Ware Intensive Residential Facility hanged herself in her room by using a bed sheet she attached to a closet door. Group sessions were being held in the dayroom that evening and when the juvenile was called for

[8] Since Ware opened in 1993, three suicides have occurred at the facility. Although OIG's review of un-redacted records covered the period from 2018 to 2022, this report also includes the suicide that occurred at Ware in 2017.

her session she did not respond. She was found by a Youth Service Worker who went to the room to check on the juvenile. Employees immediately began CPR and EMS and the Red River Parish Sheriff's Office (RRPSO) were called. A RRPSO detective arrived at 8:11 pm and EMS arrived at 8:12 pm EMS performed lifesaving measures and transported the juvenile to Christus Coushatta Hospital where she was pronounced dead.

RRPSO detectives observed that a "purple bed sheet was still hanging loosely on the top door hinge of the closet door with the end still tied in a noose fashion" inside the juvenile's assigned room. RRPSO interviewed the five other female juveniles assigned to cottage #3. None of them stated that the deceased had said she wanted to harm herself. RRPSO also interviewed Ware employees on duty in cottage #3 and those who came to assist, as well as the juvenile's mother and grandmother.

A resident of DeQuincy, Louisiana, the deceased had been at Ware since December 22, 2016 in connection with a delinquency charge in Calcasieu Parish. The juvenile's mother told RRPSO that her daughter had attempted to harm herself in the past and was taking medication for bipolar disorder.

A report prepared by a DCFS licensing specialist after an inspection cited no deficiencies.

February 7, 2019 – 17 year-old male

On February 7, 2019, a 17 year-old male resident of the Detention Center committed suicide by hanging.

The juvenile was arrested in Bossier Parish on December 26, 2018 and transferred the next day to Ware on a $500 bond to await his next scheduled court appearance. Upon initial in-processing, he was questioned by Ware security staff about his general physical and mental health. The following day, he received a more in-depth physical and mental health assessment by Ware's nurse and counselor. The juvenile was assigned to a room and allowed to make phone calls to his parents.

Between December 27, 2018 and February 2, 2019, the juvenile made 13 telephone calls to family. During one of these phone calls, he reportedly became upset and made a suicidal threat after being told he could not bond out. The juvenile also reportedly made statements to other juvenile residents

expressing thoughts of suicide. Indications are that Ware staff was not made aware of these statements, and subsequently assessed the juvenile's tendency for suicide as "low."

On February 6, 2019, the juvenile was on room confinement for disciplinary reasons and not allowed to make his scheduled phone call. On February 7, 2019 the juvenile requested to make a phone call but was denied because it was not a scheduled phone day. At 11:44 pm that night, a Ware staff member found the juvenile in a squatting or partial standing position, with a sheet tied around his neck and attached to a security bar on the room's window.

Ware staff began CPR and contacted EMS. Upon arrival, EMS medics continued CPR and transported the juvenile to Christus Coushatta Health Care Center's emergency room, where he was later pronounced dead.

Licensing regulations require that the juvenile be checked in his room by a staff member at least every 15 minutes. [LAC 67:V.7515(E)(2)(b)] Ware also has a written detention center policy that requires such room checks. [Ware Policy Number 10.14]. OIG investigators reviewed security footage from the unit where the juvenile was being housed, as well as census check logbook entries, to determine whether Ware staff complied with this policy on the night of the suicide.

This review determined that room checks were not conducted every 15 minutes as required. Although the Ware census check logbook indicated the required checks were done every 15 minutes, security footage between 9:23 pm and 11:44 pm, when the juvenile was discovered, confirms that room checks were conducted at irregular intervals that averaged 20 minutes, but actually occurred between 15 – 30 minutes.

Security footage shows that between 10:00 pm and 11:45 pm, room checks occurred at 10:13 pm, 10:42 pm, 10:58 pm and 11:44 pm, when the juvenile was discovered. On one other occasion, at 11:29 pm, the staff member was in the dayroom, but did not walk directly in front of the juvenile's room. Fifteen minutes later, the staff member discovered the juvenile hanging from the window.

February 9, 2019 – 13 year-old male

On February 9, 2019 a 13 year-old male resident of the Detention Center committed suicide by hanging.

The juvenile was arrested by the Bossier Parish Sheriff's Office (BPSO) on February 1, 2019 on a charge of aggravated arson for setting a roll of toilet paper on fire while in the boys' restroom at a Bossier Parish school.

On the evening of his arrest, the juvenile was transferred by the BPSO to Ware, and booked in at 7:05 pm. The juvenile was assigned to Room 1 in Dayroom A.

Following a detention hearing on February 4, 2019, a 26th Judicial District Court Judge ordered the juvenile remanded pending a psychiatric evaluation.

On February 5, 2019, the juvenile was moved to intake holding cell #2 for disciplinary and security reasons. Witnesses interviewed by OIG stated that during daytime hours, the juvenile was free to and did move about common areas, play video games, interact with staff and other residents, and have meals. Each night, the juvenile was placed back into holding cell #2 and the door locked until breakfast the following morning.

On the night of February 9, 2019 the juvenile was placed into intake holding cell #2 and the door locked. At 11:30 pm, he was found hanging from a sheet that had been fashioned into a knotted noose and hung from an inside door hinge. OIG investigators reviewed security footage that confirmed the last check of the juvenile's holding cell took place at 9:13 pm

Following an investigation by the Red River Parish Sheriff's Office, two Ware staff members were arrested on felony charges of malfeasance in office. One of the staff members who was arrested died in an automobile accident in July 2021. A felony prosecution against the other staff member remains pending in the 39th Judicial District Court in Red River Parish.[9] The matter is set for trial on July 29, 2024. OIG has not included further factual details that could be at issue in the criminal trial.

[9] **State of Louisiana v. Jhanquial Smith**, Case #20-140565; 39th Judicial District Court, Red River Parish

DCFS Statement of Deficiencies

Following the two 2019 suicides, DCFS issued a Statement of Deficiencies (Exhibit D) to Ware, with findings of deficiencies in the following areas:

- Staffing Requirements (Room checks every 15 minutes)
- Mental Health Assessment
- Clothing and Bedding
- Sleeping Area – Natural Lighting
- Sleeping Area – Protrusions/Tie-Off Points
- Sleeping Area – Doors

Corrective Actions By Ware

- Ware submitted a Corrective Action Plan (Exhibit E) to address the findings by DCFS.
- Ware moved all bars to the outside of windows to prevent them from being used as a tie-off point.
- Ware discontinued the use of holding cells, and the keys are now kept by the Director.
- In May 2023, Ware purchased body cameras to be worn by all Detention Youth Service Workers and Resident Advisors. These body cameras must be active at any and all times of interaction with juveniles and in areas where juveniles are present.
- Ware also implemented steps to ensure proper observation and supervision of juveniles, including the installation of Radio Frequency

Identification (RFID)[10] readers by each room to ensure that staff completes their checks every 10 minutes by physically swiping a handheld device. If the check is not physically completed within 12 minutes, a text message is automatically sent to two supervisors.

- In order to evaluate the effectiveness of Ware's RFID scanner system, OIG reviewed a sample of log reports that consisted of the first week of each month from June 2023 – April 2024. This sample contained more than 145,000 records of individual room scans in the Dayroom areas.

- DCFS regulations require that room checks do not exceed 15 minute intervals. Ware configured their system to be more conservative than DCFS regulations by setting it to log all instances where a 10 minute period had elapsed without a room check, then to flag all room checks that occurred at an interval greater than 10 minutes. The logs also show that Ware sometimes reduced the interval from 10 minutes to 5 minutes on specific rooms if they wanted to check that room more frequently.

- The system appears to work as intended where a log entry is made if the interval set by Ware is reached without a room check being logged.

- The system appears to work as intended where room checks are flagged when they exceed the interval set by Ware.

- There were 217 instances where a room check exceeded the 15 minute interval required by DCFS. This accounts for 0.15% of the 145,000 total room checks in the sample.

- Of the room checks that occurred in excess of 15 minutes, the longest any individual room went without a logged check was 31 minutes.

[10] Radio Frequency Identification (RFID) is technology that uses radio waves to identify persons and objects. https://www.dhs.gov/radio-frequency-identification-rfid-what-it

Other Actions Taken By Ware

- Ware conducts detailed screening on all potential hires that includes FBI background checks, State Central Registry maintained by DCFS, and pre-hire Psychological and Diana Sexual Risk Screening.[11]

- In 2021, Ware made more than $1 million in security upgrades and improvements to the secure care facility including erecting a new 12 foot-high fence surrounding the three secure care cottages.

- In May 2021, after a series of destructive incidents committed by juveniles at Swanson Youth Center (SCY) in Monroe, Ware agreed to accept and temporarily house several secure care juveniles from that facility. Eight juveniles were transferred to Ware from SCY and held in one dayroom of the juvenile detention facility. Others from SCY arrived later. OJJ assigned its own employees to work this area of the Ware facility. A series of similar destructive incidents were perpetrated at Ware by the SCY juveniles which caused Ware to request their removal by OJJ. Ware requested reimbursement from OJJ for repairs of the damage caused by the SCY juveniles. On August 4, 2022 OJJ reimbursed Ware more than $84,000.

PREA REPORTING AT WARE

- OIG also reviewed Ware's reporting under the **Prison Rape Elimination Act** (PREA).[12] Ware has written PREA policies that require all staff to immediately report any knowledge, suspicion, or information received regarding an incident of sexual abuse, sexual harassment or retaliation against residents or staff who report an incident.

[11] The Diana Sexual Risk Screening is a computer-based pre-hire/volunteer screening tool for use by youth serving organizations where adults serve as volunteers or staff. https://dianascreen.com/about-us/

[12] 34 U.S.C. 30301, et seq.

- OIG reviewed all Ware PREA reports from January 2017 through February 2023. There were 44 reports, including attached investigative reports from local law enforcement agencies. 38 of these cases were determined by law enforcement to be unsubstantiated and six cases were substantiated. Of the cases that were substantiated, five cases involved youth on youth and one involved a Youth Service Worker. The juveniles were arrested for committing simple battery (sexual intimidation), attempted sexual battery, and sexual battery. The Youth Service Worker was arrested for malfeasance in office.

CONCLUSIONS

- OIG, through its statutory authority, was able to access and conduct an independent review of records without redactions. Redacted records do not identify juveniles by name, and therefore it was not possible to determine from those redacted records the number or nature of incidents involving repeat offenders.

- It is also difficult to determine from redacted records which incidents involved multiple juveniles, and whether those juveniles were among the small group of repeat offenders responsible for a large percentage of critical incidents at Ware.

- During nine different visits to Ware, OIG investigators observed clean, safe and secure facilities and professional staff. Over the past three years, as part of its oversight responsibilities, OIG has physically visited every secure care facility operated by OJJ in the State of Louisiana. The Ware campus compares favorably to those other facilities.

- Notwithstanding the issues identified in this report, OIG concludes that Ware is presently a safe and secure environment suitable to house juveniles who have entered Louisiana's juvenile justice system.

APPENDIX A

WARE YOUTH CENTER

3565 HWY. 71
COUSHATTA, LOUISIANA 71019

STACI SCOTT
EXECUTIVE DIRECTOR

(318) 932-4411
FAX (318) 932-6940

April 24, 2024

Mr. Stephen B. Street
Louisiana Inspector General
602 North 5th Street Suite 621
Post Office Box 94095
Baton Rouge, LA 70802

Dear Mr. Street:

Ware Youth Center has implemented several changes since the two suicides in 2019 of [redacted] and [redacted] Ware Youth Center purchased the Guardian RFID System. The Guardian System allows for RFID tags to be mounted outside of each juvenile's room. Staff are now required to use a Ware Youth Center issued flashlight, make visual contact of the juvenile, scan the room tag before moving on to the next room. If a room check is late or missed, the system will send a text message to the Program Manager. The Program Manager will then call the facility and check in with supervisory staff to inquire why the check was late or missed. This system was purchased and installed in all Ware Youth Center Programs by 2020.

As you are aware, [redacted] was able to remove the weather stripping from around the bar on the window in his assigned room and tie a sheet around the bar. The bar was then used as a tie off point. The facility moved all bars to the outside of the windows.

As you are also aware, [redacted] was able to tie a sheet and use the hinge of the holding cell door as a tie off point. The use of the holding cells has been discontinued. I, as the Director, hold the only keys to the holding cells.

The facility has also purchased body worn cameras for Detention. Detention Staff are required to wear and activate the body worn cameras anytime they are in an area where youth are present or when they are interacting with a youth. The facility hopes to secure additional funding in the future to purchase body worn cameras for all its programs.

The facility has also purchased an alarm system that is activated after hours to prevent staff from exiting the administration area of Detention. A loud audible alarm will sound and must be reset by administrative staff.

Potential new hires are required to have an FBI Background Check and State Central Registries conducted as well as take the Diana Sexual Risk Screening and have a Pre-Hire Psychological Test performed.

In 2021, the facility once again contracted with Missouri Youth Services Institute (MYSI) to train and coach staff to use the Missouri Model in all its programs. Due to lack of funding, the facility was forced to terminate the contract, but the use of the model continues in all Ware Youth Center programs.

Also in 2021, the facility had a security fence constructed around the Intensive Residential facility. New doors and windows were also installed in the Intensive Residential Cottages to enhance the security of the facility. This was at a cost of more than a million dollars to the facility.

In 2022, the facility renovated the Detention Control Center and Fire Suppression System. The Vesda System was installed in the mechanical chases between each sleeping room. This fire and smoke detector constantly monitors the air and alerts staff at the earliest possible warning of a fire.

As noted in our letter above, the facility has made many improvements throughout the years in an effort to keep youth safe. If you have any questions or need additional information, please let me know.

Yours very truly,

Staci Scott

Staci Scott
Executive Director

SS:ml

EXHIBITS

- **Exhibit A – Aerial View of Ware Youth Center**
- **Exhibit B – DCFS Critical Incident Reporting Form**
- **Exhibit C – OJJ Unusual Occurrence Reporting Form**
- **Exhibit D – DCFS Statement of Deficiencies 2/13/2019**
- **Exhibit E – Ware Corrective Action Plan**

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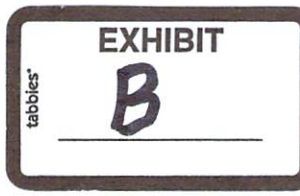
EXHIBIT A



Licensing-Critical & Other Incident Reporting Form

Instructions:

1) Fill out all sections of Incident Form
2) Return to top of page and press "File" and "Print" to print a copy of the Incident Report for your records.
3) Return to Incident Report and press "Submit" to send electronically to DCFS.

Facility Name

License Number

Type of Incident

- ○ Injury Sustained While in Seclusion or During Restraint
- ○ Unplanned Hospitalization
- ○ Suicide Attempt
- ○ Elopement
- ○ Unexplained Absence
- ○ Other

Date of Incident

Time of Incident

Resident(s) Involved in Incident

Separate names with a comma

Staff Involved in Incident or Present at the Time of Incident

Description of Incident

Action Taken as Result of Incident

Include measures taken to ensure safety and protection

Person(s) who witnessed incident

Separate names with a comma

Incident Also Reported To

- ☐ Child Welfare Placement Worker or Centralized Intake Hotline
- ☐ Office of Juvenile Justice
- ☐ Law Enforcement
- ☐ Parent/Legal Guardian
- ☐ Other

Select all applicable

List name(s) of individuals reported to if "other" is selected above.

Name of Staff Reporting Incident

Name of Staff Completing Report

Date of Completion

Print this form before hitting "Submit". Return to top right of page and press "Print" in order to print a copy of the Ir records.

EXHIBIT
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A.1.14 (a)

OFFICE OF JUVENILE JUSTICE
UNUSUAL OCCURRENCE REPORT

Was this incident: ☐ Witnessed by you ☐ Discovered by you, or ☐ Reported by you?

NAME:	CLIENT ID #:	YOUTH'S UNIT:	DATE OF INCIDENT:	TIME:

LOCATION CODE OF INCIDENT: ☐ ACY 2184 ☐ ACY-SM 2184 ☐ BCCY 2188 ☐ SCY 2182 ☐ SCYC 2182 ☐ CENTRAL OFFICE 2186 ☐ REGIONAL OFFICE_____	WITNESSES:

TYPE OF INCIDENT - CHECK APPROPRIATE BOX(ES)

	ACCIDENT		CONTRABAND –OTHER		MENTAL HEALTH		SEARCHES OF VISITORS		USE OF INTERVENTION
	AGGRAVATED UNAUTHORIZED AREA		DEATH		PERIMETER SECURITY		SEARCHES – OTHER		OTHER: CONTRACT MONITORING
	ASSAULT - YOUTH/YOUTH		ESCAPE		PREA – STAFF/YOUTH		SEXUAL MISCONDUCT		OTHER: (DESCRIBE BELOW)
	ASSAULT – YOUTH/STAFF		GANG / GANG-LIKE ORGANZIATION / ACTIVITY		PREA – YOUTH/YOUTH		TAMPERING WITH SECURITY DEVICES		
	ASSAULT – STAFF/YOUTH		KEYS – BROKEN/LOST		PROPERTY DESTRUCTION		THEFT		
	CONTRABAND – DRUGS		MAJOR DISTURBANCE		SEARCHES OF STAFF		THREATS AND INTIMIDATION		
	CONTRABAND – WEAPON		MEDICAL		SEARCHES OF YOUTH		UNAUTHORIZED AREA		

Environmental Conditions: ☐ Raining ☐ Sunny ☐ Cloudy ☐ Foggy ☐ Cold ☐ Hot ☐ Lightning ☐ Wind ☐Other: _____ ☐ Weather not a factor

Flooring: (Type of Floor and Wax)_____ Equipment: (Specify Type)_____

☐ CHEMICAL AGENT USED (CBS, ACY-SM Only) ☐ MECHANICAL RESTRAINT USED ☐ PHYSICAL RESTRAINT USED ☐ FLEX CUFFS USED
☐ MEDICAL/MENTAL HEALTH RESTRAINTS USED

DESCRIPTION OF INCIDENT (ATTACH SUPPLEMENTAL PAGE IF NEEDED) Describe incident/issue, the events that "led up to" incident/issue; what staff did to prevent this incident from happening; and how staff responded during or immediately following the incident.

___ Yes ___ No Refer youth to infirmary

___ Yes ___ No Based on the above incident, do you have reason to believe that a child's physical or mental health or welfare is endangered as a result of abuse or neglect? If YES, this incident is both Investigative Services and Office of Community Services reportable.

The following items should be attached to the UOR when applicable: pictures, medical records, victim/witness statements and supplemental reports.

Reporting Employee Signature & Title | Print Name & Title | Date Completed | Time Completed

ORM REQUIREMENTS

___ Yes ___ No Did the Supervisor/Agency safety officer receive a report of the observed conditions?

___ Yes ___ No Was the following adhered to: If the accident involved items that can be retained, it must be tagged with the date of the accident and the name of visitor/youth. Broken or damaged items must be in a secure area. Tag cannot be moved or item cannot be surplus / discarded until notified by the claims unit.

Reviewing Supervisor's Signature & Title | Print Name & Title | Date Reviewed | Time Reviewed

OFFICE OF JUVENILE JUSTICE
UNUSUAL OCCURRENCE REPORT

UOR SUPPLEMENTAL PAGE

Location Code: ☐ ACY 2184 ☐ ACY-SM 2184 ☐ BCCY 2186 ☐ SCY 2182
☐ SCYC 2182 ☐ CENTRAL OFFICE 2186 ☐ REGIONAL OFFICE_____

YOUTH NAME::	DATE OF INCIDENT:	TIME:
LOCATION OF INCIDENT:	WITNESSES:	

Continued Description of Incident:

Reporting Employee Signature & Title | Print Name & Title | Date Completed | Time Completed

EXHIBIT
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Department of Children & Family Services
Building a Stronger Louisiana

Licensing
Office of the Secretary
P.O. Box 260036
Baton Rouge, LA 70826

(O) 225.342.4350
(F) 225.663.3166
www.dcfs.la.gov

John Bel Edwards, Governor
Marketa Garner Walters, Secretary

February 25, 2019

Joey Cox, Director
Ware Youth Center - Coushatta
3565 Hwy 71
Coushatta, LA 71019

RE: License # 15596

Dear Mr. Cox:

A licensing visit was completed on February 13, 2019 at your facility. Please note the following deficiencies are being cited as a result of our Licensing investigation:

Section 7511.G.5 Staffing Requirements:
- *Youth shall be checked by a staff person at least every 15 minutes when in sleeping rooms, whether asleep or awake. Documentation of checks shall be maintained.*

Finding:
a.) Per Licensing staff review of provider documentation of visual checks done on 2/7/2019 from 10:15pm - 11:30pm versus review of the facilities video footage from this same date and time, provider had written documentation that census (room) checks were conducted on all youth during this time period leading up to the incident but the video footage does not support this claim.
b.) Per Licensing staff review of facility video footage, youth C2 was not properly checked by a staff person at least every 15 minutes while in a sleeping room as provider documentation denotes and procedure requires on 2/7/2019 at the following 15 minute increments: 10:15pm, 10:30pm, 10:45pm, 11:00pm, 11:15pm and 11:30pm.
c.) Per Licensing staff review of provider documentation of visual checks done on 2/9/2019 from 9:30pm to 11:15pm versus review of the facilities video footage from this same date and time, provider had written documentation that census (room) checks were conducted on youth during this time period leading up to the incident but the video footage does not support this claim.
d.) Per Licensing staff review of facility video footage, youth C1 was not properly checked by a staff person at least every 15 minutes while in a holding cell (being used as a sleeping room) as provider documentation denotes and procedure requires on 2/9/19 at the following 15 minute increments: 9:30pm, 9:45pm, 10pm, 10:15pm, 10:30pm, 10:45pm, 11pm, or 11:15pm.

Section 7513.E.1: Mental Health Assessment:
Youth shall receive a mental health assessment performed by a qualified mental health professional within 72 hours unless the youth was assessed within 24 hours of admission. The assessment shall include:
- *history of psychiatric hospitalizations and outpatient treatment (including all past mental health diagnoses);*
- *current and previous use of psychotropic medication;*
- *suicidal ideation and history of suicidal behavior;*
- *history of drug and alcohol use;*
- *history of violent behavior;*
- *history of victimization or abuse (including sexual victimization and domestic violence);*
- *special education history;*
- *history of cerebral trauma or seizures;*
- *emotional response to incarceration and arrest; and*
- *history of services for intellectual/developmental disabilities.*

Finding: Specialist examined 29 resident's folders, 27 current residents and 2 no longer enrolled residents (C1 and C2), and of the 29, 18 failed to have a mental health assessment completed within at least 72 hours of admission. Of the 18, 3 were transfers from the owner's adjacent residential licensed facility and S1 stated since the counselor and owner were the same for both facilities, S1 did not believe they needed to do a new assessment once the youth were admitted into their juvenile detention facility. Of the remaining 15, the time these assessments were completed after the 72-hour allowance ranged from 1 day late to 26 days late.

7517.B.3: Clothing and Bedding:

- *The provider shall maintain an inventory of clothing, and bedding to ensure consistent availability and replacement of items that are lost, destroyed, or worn out.*
- *The provider shall provide clean underclothing, socks, and outerwear that fit properly.*
- *The provider shall provide for the thorough cleaning and when necessary, disinfecting of youth's personal clothing.*
- *The provider shall issue clean bedding and linen, including two sheets, a pillow, pillowcase, a mattress, and sufficient blankets to provide reasonable comfort.*
- *Linen shall be exchanged weekly and towels exchanged daily.*

Finding: Per staff testimony, as a precaution resulting from the incident that occurred on 2/9/2019, on 2/10/2019, provider removed the sheets and pillow cases from all residents, thereby leaving them with only a pillow, a mattress, and a thick wool blanket as part of their bedding and linen. Staff stated they were unsure when they would give the residents back their sheets and pillowcases.

7519.D.5: Sleeping Area- Natural Lighting:

The provider shall not use any room that does not have natural lighting as a sleeping room.

Finding: Per staff testimony, the facility uses their holding cells as temporary sleeping rooms when needed i.e. when a resident is a danger to themselves or others and/or if something is broken in their own permanent cell. Per specialist's observation, these holding cells do not have any windows; therefore, they do not have natural light as should not be used as a sleeping room.

7519.D.6: Sleeping Area- Protrusions/Tie-Off Points:

The provider shall remove protrusions and other tie-off points from rooms.

Finding: Per specialist's observation, there was a tie-off point in C2's cell. C2 was in a cell with a window which had a metal bar in front of the window. Specialist observed a gap between the bar and window about ¾ inch wide, an area large enough to tie off a sheet, blanket, pillow case, shirt, etc. between the two such as was done by C2 regarding the incident on 2/7/2019. Staff stated all cells are constructed like this one, excluding the temporary holding cells, which have no windows.

7519.D.7: Sleeping Area- Doors

The doors of every sleeping room shall have a view panel that allows complete visual supervision of all parts of the room. The view panel shall be one-quarter inch tempered or safety glass panels at least 10 inches square.

- *Doors shall be hinged to a metal frame set securely in the wall with sound insulation strips on the jamb.*
- *Hinge pins of doors shall be tamperproof and non-removable.*
- *In newly constructed or renovated facilities doors to sleeping rooms shall be arranged alternately so that they are not across the corridor from each other.*
- *Each youth's housing door shall be hung so that it opens outward, in the opposite direction of the youth living area, or slide horizontally into a recessed pocket in order to prevent the door from being barricaded.*

Finding: Per specialist's observation, the holding cells, which are used as temporary sleeping rooms do not have doors that open outwardly, in the opposite direction of the youth living area, nor do they slide horizontally into a recessed pocket in order to prevent the door from being barricaded. These doors open inward, into the youth sleeping area.

Attached is an addendum to the deficiencies on a CCL 04 form. As with any deficiencies noted, you may submit a written response including your plans for correction. Deficiencies noted could affect the licensing status of this facility and/or place the children in danger. A follow-up inspection may be conducted to determine corrections have been made. If you have any questions regarding this matter, please contact Joy Legaux, Licensing Supervisor at (225) 342-4350.

Sincerely,

Joy Legaux, Licensing Supervisor

Attachment

CCL 4 JDF
Rev. 11/14
06/12 Issue Obsolete

LOUISIANA DEPARTMENT OF CHILDREN & FAMILY SERVICES
LICENSING – OFFICE OF THE SECRETARY
P.O. BOX 260036, BATON ROUGE, LA 70826
225-342-4350

STATEMENT OF DEFICIENCIES

I. FACILITY: Ware Youth Center – Coushatta

ADDRESS: 3565 Highway 71, Coushatta, LA 71019

DCFS STAFF: M. Scott Brooks DIRECTOR: Joey Cox

LIC. EXP. DATE: 7/31/19 LICENSE #: 15596 ANNIV. MO.: July

CENSUS: 31 # OF DEFS. FROM PREVIOUS VISIT: NA

CAPACITY: 33 # OF DEFICIENCIES CLEARED: NA

CLASS TYPE: JD # OF DEFICIENCIES RE-CITED: NA

ACTION CODE: 23 # OF NEW DEFICIENCIES: 6

CONTROL #: NA **TOTAL DEFICIENCIES:** 6

II. THE FOLLOWING LICENSING DEFICIENCIES REQUIRE PROMPT CORRECTION:

1.) Section 7511.G.5 Staffing Requirements:
Youth shall be checked by a staff person at least every 15 minutes when in sleeping rooms, whether asleep or awake. Documentation of checks shall be maintained.

Finding:

- Per Licensing staff review of provider documentation of visual checks conducted on 2/7/2019 from 10:15pm - 11:30pm versus review of the facilities video footage from this same date and time, provider had written documentation that census (room) checks were conducted on all youth during this time period leading up to the incident; however, the video footage does not support this claim.
- Per Licensing staff review of facility video footage, youth C2 was not properly checked by a staff person at least every 15 minutes while in a sleeping room as provider's documentation denotes and procedure requires on 2/7/2019 at the following 15 minute increments: 10:15pm, 10:30pm, 10:45pm, 11:00pm, 11:15pm, and 11:30pm.
- Per Licensing staff review of provider documentation of visual checks conducted on 2/9/2019 from 9:30pm to 11:15pm versus review of the facilities video footage from this same date and time; provider had written documentation that census (room) checks were conducted on youth during this time period leading up to the incident; however, the video footage does not support this claim.
- Per Licensing staff review of facility video footage, youth C1 was not properly checked by a staff person at least every 15 minutes while in a holding cell (being used as a sleeping room) as provider documentation denotes and procedure requires on 2/9/19 at the following 15 minute increments: 9:30pm, 9:45pm, 10pm, 10:15pm, 10:30pm, 10:45pm, 11pm, or 11:15pm.

2.) Section 7513.E.1: Mental Health Assessment:
Youth shall receive a mental health assessment performed by a qualified mental health professional within 72 hours unless the youth was assessed within 24 hours of admission. The assessment shall include:

- *history of psychiatric hospitalizations and outpatient treatment (including all past mental health diagnoses);*
- *current and previous use of psychotropic medication;*
- *suicidal ideation and history of suicidal behavior;*
- *history of drug and alcohol use;*
- *history of violent behavior;*
- *history of victimization or abuse (including sexual victimization and domestic violence);*
- *special education history;*
- *history of cerebral trauma or seizures;*
- *emotional response to incarceration and arrest; and*
- *history of services for intellectual/developmental disabilities.*

Finding:

- Specialist examined 29 resident's folders, 27 current residents and 2 no longer enrolled residents (C1 and C2), and of the 29, 18 failed to have a mental health assessment completed within at least 72 hours of admission. Of the 18, 3 were transfers from the owner's adjacent residential licensed facility and S1 stated since the counselor and owner were the same for both facilities, S1 did not believe they needed to do a new assessment once the youth were admitted into their juvenile detention facility. Of the remaining 15, the time these assessments were completed after the 72-hour allowance ranged from 1 day late to 26 days late.

3.) 7517.B.3: Clothing and Bedding:

The provider shall maintain an inventory of clothing, and bedding to ensure consistent availability and replacement of items that are lost, destroyed, or worn out.

- *The provider shall provide clean underclothing, socks, and outerwear that fit properly.*
- *The provider shall provide for the thorough cleaning and when necessary, disinfecting of youth's personal clothing.*
- *The provider shall issue clean bedding and linen, including two sheets, a pillow, pillowcase, a mattress, and sufficient blankets to provide reasonable comfort.*
- *Linen shall be exchanged weekly and towels exchanged daily.*

Finding:

Per staff testimony, as a precaution resulting from the incident that occurred on 2/9/2019, on 2/10/2019, provider removed the sheets and pillow cases from all residents, thereby leaving them with only a pillow, a mattress, and a thick wool blanket as part of their bedding and linen. Staff stated they were unsure when they would give the residents back their sheets and pillowcases.

4.) 7519.D.5: Sleeping Area- Natural Lighting:

The provider shall not use any room that does not have natural lighting as a sleeping room.

Finding:

Per staff testimony, the facility uses their holding cells as temporary sleeping rooms when needed i.e. when a resident is a danger to themselves or others and/or if something is broken in their own permanent cell. Per specialist's observation, these holding cells do not have any windows; therefore, they do not have natural light and should not be used as a sleeping room.

5.) 7519.D.6: Sleeping Area- Protrusions/Tie-Off Points:

The provider shall remove protrusions and other tie-off points from rooms.

Finding:

Per specialist's observation, there was a tie-off point in C2's cell. C2 was in a cell with a window which had a metal bar in front of the window. Specialist observed a gap between the bar and window about ¾ inch wide, an area large enough to tie off a ~~sheet, blanket, pillow case, shirt, etc. between the two such as was done by C2 regarding the incident on 2/7/2019.~~ Staff stated all cells are constructed like this one, excluding the temporary holding cells, which have no windows.

6.) 7519.D.7: Sleeping Area- Doors

The doors of every sleeping room shall have a view panel that allows complete visual supervision of all parts of the room. The view panel shall be one-quarter inch tempered or safety glass panels at least 10 inches square.

- *Doors shall be hinged to a metal frame set securely in the wall with sound insulation strips on the jamb.*
- *Hinge pins of doors shall be tamperproof and non-removable.*
- *In newly constructed or renovated facilities doors to sleeping rooms shall be arranged alternately so that they are not across the corridor from each other.*
- *Each youth's housing door shall be hung so that it opens outward, in the opposite direction of the youth living area, or slide horizontally into a recessed pocket in order to prevent the door from being barricaded.*

Finding:

Per specialist's observation, the holding cells, which are used as temporary sleeping rooms do not have doors that open outwardly, in the opposite direction of the youth living area, nor do they slide horizontally into a recessed pocket in order to prevent the door from being barricaded. These doors open inward, into the youth sleeping area.

I hereby acknowledge the following:

- I have received the Statement of Deficiencies that was left on-site.
- I understand that these deficiencies could affect the licensing status of this facility and/or place the youth in danger. _____ (provider to initial)

C

- A follow-up inspection may be conducted to determine that corrections have been made and maintained in a manner consistent with the minimum standards.
- Revocation of a license will result in the department not accept a subsequent application for this facility or any new facility for a minimum period of two years after the effective date of revocation or non-renewal or a minimum period of two years after all appeal rights have been exhausted, whichever is later (the disqualification period) _(provider to initial)
-The actual names of staff members as noted throughout the Statement of Deficiencies as S1, S2, C1, C2, O1, O2,etc. were identified, discussed and provided to me during the exit interviews. _____(provider to initial)
- The DCFS website contains information relating to the operation of licensed facilities and should be checked periodically for new and updated information. _____ (provider to initial)
-I have been informed that I may submit a corrective action plan regarding correction of these deficiencies ASAP, but no later than 14 days from receipt of this notification. _____(provider to initial)
-The exit interview with licensing specialist consisted of a review of each deficiency cited as well as consultation on how to correct and maintain compliance with the minimum standards. _____(provider to initial)

02/25/2019
Date sent via email to Provider

Director Signature

Addendum to Licensing inspection conducted on 2/13/2019

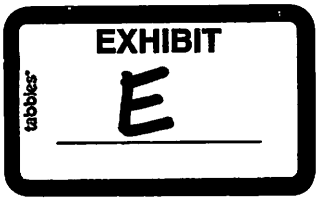
FACILITY: Ware Youth Center – Coushatta LICENSE #: 15596

DATE RECEIVED BY OR
MAILED TO PROVIDER: 2/25/2019 ACTION CODE: 23 CONTROL #: NA

Resident Identifiers
C1 - [redacted]
C2 - [redacted]

Staff Identifier
S1—Staci Scott

Director's Initials: _____



WARE YOUTH CENTER

3565 HWY. 71
COUSHATTA, LOUISIANA 71019

JOEY L. COX
EXECUTIVE DIRECTOR

(318) 932-4411
FAX (318) 932-6940

March 5, 2019

Department of Children and Family Services
Division of Programs
Licensing Section
P.O. Box 260036
Baton Rouge, LA 70826

Re: Corrective Action Plan

To Whom It May Concern:

Ware Youth Center Detention, License Number 15596, is submitting the following Corrective Action Plan regarding the noted deficiencies:

7511G.5: Staffing Requirements – The facility will retrain all staff on the proper procedures for logbook entries specifically relating to documentation of room checks. The facility will also retrain staff on proper visual checks as required by policy and procedure. The facility has also purchased a new system called the Guardian RFID. The Guardian RFID System uses Hard Tags that will be mounted to the outside of each room (beside the window). Staff will use a handheld Android device to scan each hard tag. This scan collects data in real time and uses Cloud based reporting that can be accessed from any computer or smart device. The system will alert staff when a room check is due or when a room check is missed. The system will also send an email alert to a Manager if a room check has been missed. It also generates reports that can be filtered by date, time, staff, shift, location, juvenile name, and activity monitored while making the room check. This system was purchased in an effort to help ensure staff are conducting room checks consistently and in a timely manner.

7513.E.1: Mental Health Assessment – The facility has hired a full time Masters Level Case Manager for Detention and will no longer be relying on Case Managers from other programs to conduct Intake Assessments on Detention youth.

7517.B.3: Clothing and Bedding – The facility is aware of this requirement however, both suicides involved youth tying sheets around their necks. In an effort to keep all youth safe and to prevent a copycat incident, all sheets and pillowcases were removed and all youth were placed on suicide watch with staff making five minute room checks.

7519.D.5: Sleeping Area – Natural Lighting – The facility is not currently using either Holding Cell for housing youth, however both holding cells do have natural lighting that comes from the outside windows in the Intake Office that is located directly across from the Holding Cells and also the Sally Port area. Please see attached photos.

7519.D.6: Sleeping Area – Protrusions/Tie-Off Points – These rooms have been in use since 1993. The facility is in the process of making adjustments to the space in the window. DCFS will be contacted for review and approval once the modification has been made.

7519.D.7: Sleeping Area – Doors – These Holding Cells have been in use since the facility opened in 1993. The facility is not currently using either Holding Cell for housing youth however, when the Department of Children and Family Services Licensing Division began licensing Detention facilities again, we believe that existing room and layout would be permitted to be used (grandfathered in) as long as they were maintained and in working order.

Please let me know if you need any additional information.

Yours very truly,

Joey L. Cox
Executive Director

JC:ss
Enclosure