Department of Children & Family Services
Building a Stronger Louisiana

Bureau of General Counsel
Executive Division
Post Office Box 1887
Baton Rouge, LA 70821

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John Bel Edwards, Governor
Marketa Garner Walters, Secretary

April 12, 2019

Mr. Craig Williams
Attorney at Law
Marioneaux & Williams
1201 Hawn Avenue
Shreveport, Louisiana 71107

Via FedEx: 8129 9837 4694

RE: Public Records Request
Ware Youth Center-Coushatta-Investigation
Zachary Solan Peterson
Jordan Bachman

Dear Mr. Williams,

Enclosed please find the records you requested in connection with the licensing visit and/or investigation of the deaths of Zachary Solan Peterson and Jordan Bachman. Please note that while licensing documents are public records, confidential information has been redacted in accordance with La. R.S. 46:56.

A flash drive with video and photographs will be forwarded once protected information is redacted.

Please feel free to call or email me with any questions you may have.

Sincerely,

Attorney III

Enclosures

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

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
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John Bel Edwards, Governor
Marketa Garner Walters, Secretary

March 21, 2019

Joey Cox, Director
Ware Youth Center - Coushatta
3565 Highway 71
Coushatta, La 71019

RE: License #15596

Dear Mr. Cox:

The Department of Children and Family Services completed an on-site inspection on February 3, 2019 and cited six deficiencies. We are in receipt of your Corrective Action Plan (CAP) submitted in response to the deficiencies cited on the above referenced date. Upon review of your plan, please note the following with regard to each section cited:

Section 7511.G.5 Staffing Requirements:
Your plan is acceptable for Licensing purposes

Section 7513.E.1: Mental Health Assessment:
Your plan is acceptable for Licensing purposes

7517.B.3: Clothing and Bedding:
It is not acceptable to place all youth on suicide watch because of an incident that occurs involving one specific youth at your facility. This regulation requires the provider to *"issue clean bedding and linen, including two sheets, a pillow, pillowcase, a mattress, and sufficient blankets to provide reasonable comfort."* Please provide additional information regarding your plan to ensure this regulation is met even when a suicidal incident occurs involving one specific youth at your facility.

7519.D.5: Sleeping Area- Natural Lighting:
The intent of this regulation is for each sleeping room to have its own window that allows for natural lighting. Because your holding cells do not have their own window, they are not considered to be sleeping rooms according to the current regulations. As such, they shall not be used for sleeping by youth. If there is a reason that you now have to use the holding cells as sleeping rooms, you must request a waiver for this regulation and for all other regulations under Section 7519.D (Sleeping Areas) that the holding cells do not meet. Your waiver should explain why the holding cells need to be used as sleeping rooms and your plan for meeting the intent of the standards you are requesting to be waived.

7519.D.6: Sleeping Area- Protrusions/Tie-Off Points:
You advised that the modifications to the bars in the windows were complete. Licensing will complete a follow up inspection to determine corrections have been made.

7519.D.7: Sleeping Area- Doors
Because your holding cells do not have their own window, they are not considered to be sleeping rooms according to the current regulations. As such, they shall not be used for sleeping by youth. If you were not granted a waiver by the Secretary for this requirement prior to be being licensed that would allow you to use the holding cells as sleeping rooms and for the holding cell doors to open inwardly, the use of holding cells as sleeping rooms are not permitted. If there is a reason that you now have to use the holding cells as sleeping rooms, you must request a waiver for this regulation and for all other regulations under Section 7519.D (Sleeping Areas) that the holding cells do not meet. Your waiver should explain why the holding cells need to be used as sleeping rooms and your plan for meeting the intent of the standards you are requesting to be waived.

Failure to implement the CAP as evidenced by a repeated citation of the same categories may result in revocation/non-renewal of your license, or both.

The health and safety of the youth placed in juvenile detention facilities are of paramount concern for the Department of Children and Family Services. As such, we appreciate your cooperation and expect compliance with the standards detailed in the Juvenile Detention Licensing Regulations.

Please contact Joy Legaux, Licensing Supervisor at 225-342-4350 with any questions regarding this letter.

Sincerely,

Angie Badeaux, LCSW
Licensing Director

AB/jl

To: Joy Legaux, Licensing Supervisor

From: M. Scott Brooks, Licensing Specialist

RE: Ware Youth Center – Coushatta, License #15596

Date: March 29, 2019

Listed below are the observations made by myself and testimonies to specialist by Assistant Director Staci Scott as related to the changes made to this noted detention center as part of specialist's consultation visit (action code 4) conducted at the facility on March 6, 2019.

1.) The facility made a physical change to one of their detention cells: they removed the bar previously located inside the cell. The facility removed the bar and reattached it to the other side of the window, a space inaccessible to the detainees. Specialist observed the space where the bar was previously located to be smooth to the touch at both the top and bottom points of the window frame. There does not appear to be any gaps or points of note as related to the window which would violate any Licensing regulation at this time (pictures have been previously sent).

2.) Also while examining this change, specialist observed the desk with an attached seat that is located in each cell (pictures have been previously sent). There is a bar which connects the table top to the bar of the seat that is 14 inches vertical, then there is bar from that previously noted bar that goes to the seat that is 12 inches horizontal, and finally there is a bar that goes from the seat to the ground that is 14 inches vertical.

3.) Regarding the holding cells, Mrs. Scott stated the facility has made no physical changes to those 2 cells at this point in time, but they are considering making a change to the door hinges, which are currently located on the inside of the cell. Mrs. Scott stated they are not using these cells at this time at all, whether as a sleeping cell, temporary holding cell, or in any capacity at all.

3/29/19

Ware Youth Center
Incident Report

Name of Person Filing Report: [redacted] Date of Report: 2/08/2019

Name of all persons involved: [redacted] - Juvenile
Travis Howard – Shift Supervisor
Kenyardah Jones – Childcare Worker I
Shamaria Cole – Childcare Worker I
Melanie Hearold – Nurse

Date of incident: 2/07/2019 Time of Incident: 11:45 p.m.

Location of Incident: Detention – Dayroom B, Room #12

Nature of Incident: At approximately 12:06 a.m., on 2/08/2019, I received a phone call from facility nurse Melanie Hearold who stated Detention juvenile [redacted] was unresponsive. Nurse Melanie stated staff had called 911 and EMS was in route. Nurse Melanie also stated that staff had begun CPR. EMS arrived and transported juvenile [redacted] to Christus Coushatta Emergency Room where he was pronounced dead by Dr. Martin Carter. I notified Director Joey Cox and Program Manager Raymond Lloyd.

Staff present at the time of the incident: Shift Supervisor Travis Howard, Childcare Worker Kenyardah Jones and Childcare Worker Shamaria Cole

I spoke to Childcare Worker Kenyardah Jones who stated the following:

Childcare Worker Jones stated that he had made his 11:30 p.m. census check in Dayroom B. Juvenile [redacted] had asked Childcare Worker Jones for the time. Childcare Worker Jones stated he told [redacted] the time and continued making his round. Childcare Worker Jones stated at 11:45 p.m., when he went to make his next round, he found juvenile [redacted] with a sheet tied around his neck and tied to the bar in the window. Childcare Worker Jones stated the juvenile [redacted] was leaning forward causing the sheet around his neck to restrict his airway. Childcare Worker Jones said he immediately called for Shift Supervisor Travis Howard and also called 911. Childcare Worker Jones stated he and Shift Supervisor Howard removed the sheet from around juvenile [redacted] neck and immediately started CPR. Childcare Worker Jones stated he could feel a faint pulse. Childcare Worker Jones said he and Shift Supervisor Howard continued to do CPR until EMS arrived and transported juvenile [redacted] to the hospital.

I spoke to Shift Supervisor Travis Howard who stated the following:

Shift Supervisor Howard stated that Childcare Worker Jones had called him to come to Dayroom B, room #12 to help him with juvenile [redacted] Shift Supervisor Howard stated when he arrived to the room, he and Childcare Worker Jones removed the sheet from around juvenile [redacted] neck, laid him on the floor and began CPR. Shift Supervisor

Howard stated that Childcare Worker Jones called 911. Shift Supervisor Howard stated he and Childcare Worker Jones continued to perform CPR until EMS arrived and took over care of juvenile [redacted]
I spoke to Childcare Worker Shamaria Cole who stated the following:

Childcare Worker Cole stated she was doing her census check on the female juveniles when she heard Childcare Worker Jones tell Shift Supervisor Travis Howard that he needed assistance in Dayroom B, room #12. Childcare Worker Cole stated she heard Childcare Worker Jones call Shift Supervisor Howard for assistance. She stated she returned to the Staff Station to wait on EMS so she could let them into the building.

Notes: I, along with Program Manager Raymond Lloyd personally reviewed the video that showed Childcare Worker Jones makes his 11:30 p.m. room check and again at 11:45 p.m. During the 11:45 p.m. check is when Childcare Worker Jones discovered juvenile [redacted]. I submitted a Critical Incident Report to DCFS Licensing and also called the DCFS Hotline to report juvenile [redacted] death. I spoke to DCFS Case Worker Marshall Lewis at approximately 1:56 a.m. on 2/08/2019.

Notifications:

Joey Cox, Director
Raymond Lloyd, Program Manager
Red River Parish Sheriff's Office Detective David Hensley
Debbie Vascocu, Charge Nurse
Critical Incident to DCFS Licensing
DCFS Hotline – Marshall Lewis
Joy Legeaux, DCFS Licensing
, mother) was notified by Detective David Hensley
District Attorney Schuyler Marvin

[redacted] 2/8/19
Date

6-3-09 DS

INCIDENT REPORT
(PLEASE PRINT OR TYPE)

NAME OF PERSON FILING REPORT: Travis Howard **DATE OF REPORT:** 2-7-19

NAME OF ALL PERSONS INVOLVED: Travis Howard - CCWII
Kenyardah Jones - CCWI
Shamira Cole - CCWI
[redacted] (jur)

DATE OF INCIDENT: 2-7-19 **TIME OF INCIDENT:** 1145 **AM/PM**

LOCATION OF INCIDENT: B-Pod #12

Each staff member directly or indirectly involved in the incident should file a separate incident report. Do not collaborate in writing one report. Try to answer in your report the who, what, where, when and why questions: be objective in your statements.

NATURE OF INCIDENT: While I Travis Howard (CCWII) was doing my census check at 11:45pm on D-side. Kenyardah Jones (CCWI) ran to D-side and told me Travis Howard (CCWII) that he needed assistant to B-Pod because [redacted] (jur) was hanging himself with a sheet tied

TYPE OF INCIDENT

RESIDENT-ON-RESIDENT ASSAULT	____	RESIDENT-ON-STAFF ASSAULT	____
SUBSTANCE RELATED	____	PROPERTY EVENT	____
SEXUAL MISCONDUCT	____	POSSESSION OF CONTRABAND	____
SELF HARM	____	SUICIDE	____
PERSONAL INJURY	____	OTHER	____

ACTION TAKEN: Contacted PM Mr. Raymond Lloyd, Nurse Melanie and call 911

RESULTS OF ACTION:

YOUR OPINION AS TO WHY THE INCIDENT TOOK PLACE:

Use Incident Report Supplement for other or additional information.

SUPPLEMENTAL PAGES ATTACHED? ✓ **YES** ____ **NO**

SIGNATURE OF STAFF COMPLETING REPORT: Travis Howard

SIGNATURE OF SHIFT SUPERVISOR: Travis Howard

INCIDENT REPORT SUPPLEMENT

Page ___ of ___

to the window. I Travis Howard (CCWI) and Kenyardah Jones (CCWI) went inside Cell #12 in B Pod I Travis Howard (CCWI) picked up [redacted] (jur) and Kenyardah Jones (CCWI) took the sheet from around [redacted] (jur) neck. While I Travis Howard and Kenyardah Jones (CCWI) was doing CPR Ms. Shamira Cole (CCWI) was calling Mr. Raymond (PM), Nurse Melanie, and 911. Mr. Jones and myself Howard continue CPR until help came.

End of Report
2-9-19
Travis Howard

19/irs.frm/ml

6-3-09 DS

INCIDENT REPORT
(PLEASE PRINT OR TYPE)

NAME OF PERSON FILING REPORT: Shamaria Cole **DATE OF REPORT:** 2/7/19

NAME OF ALL PERSONS INVOLVED: Shamaria Cole (CCWI)
Travis Howard (CCWII)
Kenyaradah Jones (CCWI)
[redacted] (JVV)

DATE OF INCIDENT: 2/7/19 **TIME OF INCIDENT:** 11:47pm AM (PM)

LOCATION OF INCIDENT: B-pod Cell #12

Each staff member directly or indirectly involved in the incident should file a separate incident report. Do not collaborate in writing one report. Try to answer in your report the who, what, where, when and why questions: be objective in your statements.

NATURE OF INCIDENT: Around 11:47pm at night Kenyardah Jones was completing his check around in B-side. As he was examining he noticed that JVV. [redacted] had his bed sheet from his bed wrapped around his neck. He then ran to get the supervisor, Travis Howard and they began doing chest compressions and mouth to mouth. I, Ms. Cole (CCWI)

TYPE OF INCIDENT

RESIDENT-ON-RESIDENT ASSAULT	____	RESIDENT-ON-STAFF ASSAULT	____
SUBSTANCE RELATED	____	PROPERTY EVENT	____
SEXUAL MISCONDUCT	____	POSSESSION OF CONTRABAND	____
SELF HARM	____	SUICIDE	✓
PERSONAL INJURY	____	OTHER	____

ACTION TAKEN: JVV. [redacted] was untied from bed sheet and Mr. Howard & Mr. Jones began doing chest compressions, while waiting on the ambulance to make it.

RESULTS OF ACTION: JVV. [redacted] was transported to the Christus Cushatta hospital by ambulance.

YOUR OPINION AS TO WHY THE INCIDENT TOOK PLACE: n/a

Use Incident Report Supplement for other or additional information.

SUPPLEMENTAL PAGES ATTACHED? ✓ **YES** ____ **NO**

SIGNATURE OF STAFF COMPLETING REPORT: Shamaria Cole

SIGNATURE OF SHIFT SUPERVISOR: ____

INCIDENT REPORT SUPPLEMENT

began to call mr. Raymond, and then I called Nurse Melanie to get further assistance to help the juv. Nurse melanie began telling me what to tell mr. Jones and mr. Howard what to do as far as chest compressions. I, ms. Cole, (CCW1) then went to medical room and grabbed what Nurse melanie told me to grab. I believe it was the blood pressure cuff, and to check to see if he's still had a pulse. By that time mr. Jones had already called all about 10-20 minutes prior. As I stayed on the phone in B-pod with Nurse Melanie, mr. Howard (CCW11) continued to do chest compressions. mr. Jones was at the staff station waiting on the ambulance to enter. One paramedic came, and hooked the machine up to juv. [redacted] and tried to get some airway flowing. He charged him about two times, and then the rest of the ambulance/paramedics made it. They began doing chest compressions, and they charged juv [redacted] about three or four times, and afterwards they took juv. [redacted] out on the stretcher. Afterwards I then talked to mr. Raymond, and [redacted] and gave a brief summary of what happened. By that time Nurse Melanie had made it, as well as the sheriff's/detectives.

Shamaria Cole
2/8/2019

~ end of report ~

19/irs.frm/ml

6-3-09 DS

INCIDENT REPORT
(PLEASE PRINT OR TYPE)

NAME OF PERSON FILING REPORT: Kenyardah Jones **DATE OF REPORT:** 2-7-19

NAME OF ALL PERSONS INVOLVED: Kenyardah Jones CCWI
Travis Howard CCWII
Shamaria Cole CCWI
[redacted] (W)

DATE OF INCIDENT: 2-7-19 **TIME OF INCIDENT:** 11:45 **AM/PM**

LOCATION OF INCIDENT: B pod Cell #12

Each staff member directly or indirectly involved in the incident should file a separate incident report. Do not collaborate in writing one report. Try to answer in your report the who, what, where, when and why questions: be objective in your statements.

NATURE OF INCIDENT: while doing my 11:30pm Census Check [redacted] ask me for the time. I Kenyardah Jones told [redacted] 11:30pm. I found [redacted] on my routine check at 11:45pm hanging from his window with the bed sheet. I didn't want to panic I ran to get Mr. Howard who was doing a Check in D pod

TYPE OF INCIDENT

RESIDENT-ON-RESIDENT ASSAULT	____	**RESIDENT-ON-STAFF ASSAULT**	____
SUBSTANCE RELATED	____	**PROPERTY EVENT**	____
SEXUAL MISCONDUCT	____	**POSSESSION OF CONTRABAND**	____
SELF HARM	____	**SUICIDE**	____
PERSONAL INJURY	____	**OTHER**	____

ACTION TAKEN: I went to get my Supervisor, then we both took turns doing CPR. I then Stopped to call 911 as Mr. Howard Continued once I got off the phone I went back to helping Mr. Howard with the CPR

RESULTS OF ACTION: Ambulance Came, They got [redacted] and took him to the hospital.

YOUR OPINION AS TO WHY THE INCIDENT TOOK PLACE: His family, maybe his girlfriend and being locked up. I think he couldn't take the Stress of being in here anymore.

Use Incident Report Supplement for other or additional information.

SUPPLEMENTAL PAGES ATTACHED? ✓ **YES** ____ **NO**

SIGNATURE OF STAFF COMPLETING REPORT: Kenyardah Jones

SIGNATURE OF SHIFT SUPERVISOR: ____

INCIDENT REPORT SUPPLEMENT

to come help me get him down and do CPR. It was hard not to get emotional but I knew I had a job to do.

The end of report
2-7-19
Kenyardah Jones

19/irs.frm/ml

Ware Youth Center-Coushatta

3565 Highway 71

Coushatta, LA 71019

License #15596

Incident – 2/7/2019 – Memo

Here is the additional information obtained by specialist on this incident while investigating another incident at the facility on 2/12/19 and 2/13/19.

Room Checks

C2 was found at 11:45pm while S8 was conducting the required 15-minute visual check of facility cells. Specialist examined the facility's video footage of the matter. Regarding the 11:30pm required visual check, specialist did observe S8 (as noted to specialist by S1) walk past cells on the far wall, then make his way up the wall of cells that included C2's. However, from specialist's perspective of the video, it appears S8 never made it to C2's cell during this check. C2 was in cell 12 per S1 and, from the video, it appears S8, after passing cell 11, cut off from examining the rest of the cells along that wall and left out of this section of the facility. S1 stated there were residents in cells 13 and 15, and from the video footage, it is clear and obvious no visual check was done for these 2 cells at this time. Specialist reviewed the 11:15pm time; there was no visual check done for either C2 or any other detainee in this section at this time. Specialist then reviewed the 11pm time, and there was evidence S8 (as noted to specialist by S1) walking past each of the cells. These visual checks did not include S8 stopping and peering in as providers procedure requires, but merely walking past. S1 stated staff have a little flashlight they shine into the cells to verify the residents are lying down. Video evidence does not support the use of a flashlight by S8 as part of his visual checks. At 11:45pm, per the video footage, S8 walked by C2's cell, but went past it, then did a double take and found him as noted on the documented incident report.

Specialist also examined the cell where the incident occurred. S5 and S6 stated that C2 had tied a sheet to the metal bar located in front of the window then around his neck. Specialist examined the noted space and found a gap between the bar and the window wide enough to do as noted. Specialist measured the gap to be about ¾ of an inch wide. S5 and S6 stated all the cells are the same in this manner.

Licensing supervisor reviewed facility video footage and observed that youth C2 was not also 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 and 10:45pm. For the 10:15pm and 10:45pm room checks, S8 was observed walking past each of the cells. For the 10:30 room check, there was no recorded movement noted by any staff on video in the cell area for this particular timeframe.

Other

Both S5 and S6 stated, and this was verified via facility documentation, C2 has never been on suicide watch while at the facility. Per facility documentation, C2 received his mental health assessment timely after intake.

Staff response

Per S1 and S2, as a result of the incident they are considering both removing the bar and placing it on the outside of the glass as well as leaving the bar where it currently is located and welding a piece of metal between the bar and the glass thereby preventing anything from being threaded between the bar and the glass.

M. Sc. H. Brel
21-02-19

21 Feb 19

Staff Identifiers

S1 – Staci Scott

S2 – Joey Cox

S5 – Lamonda Newman

S6 – Jermey Horton

S8 – Kenyardah Jones

Resident Identifier

Q – [redacted]

February 8, 2019

Ware Youth Detention Center

3565 Highway 71

Coushatta, LA 71019

License #15596

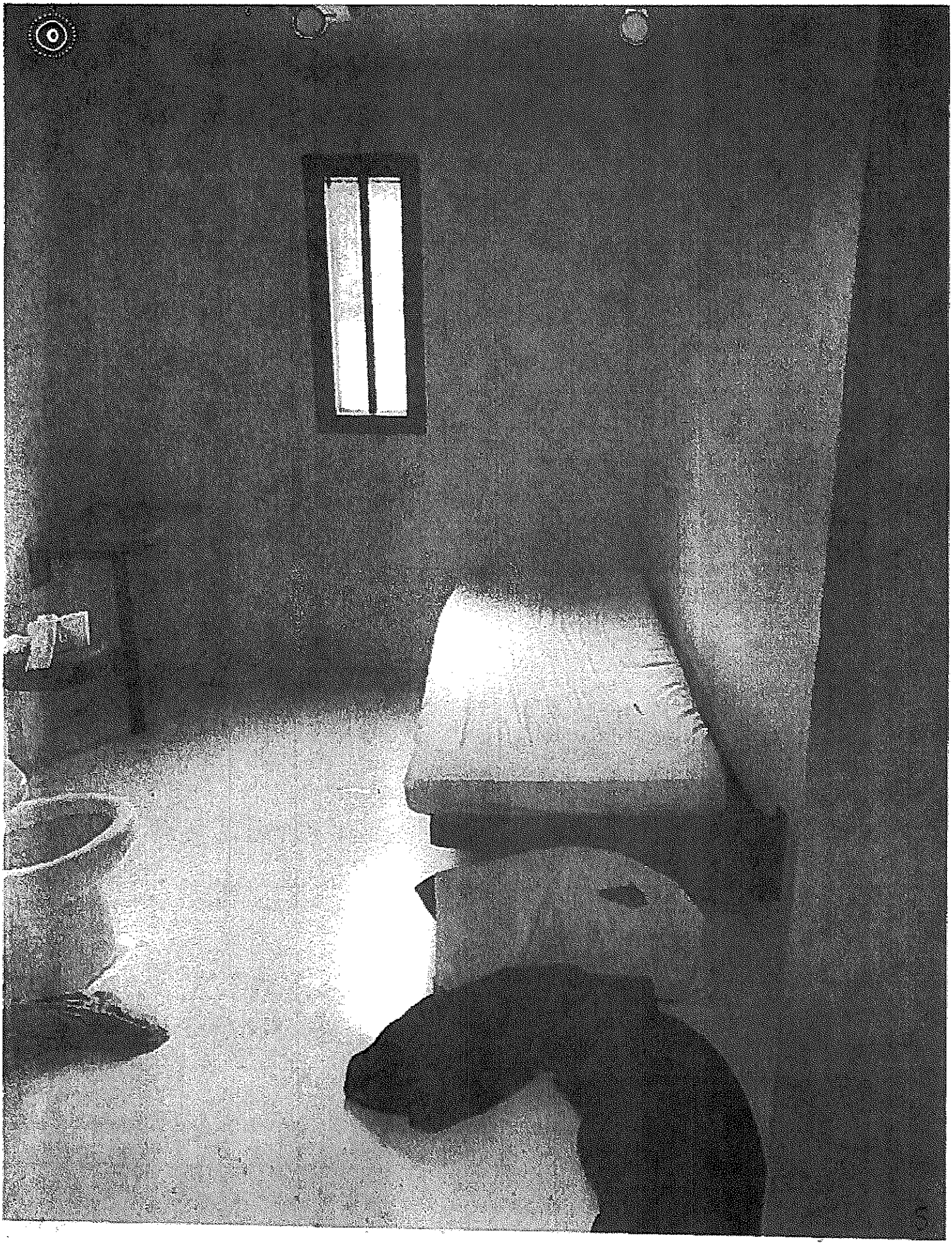
RE: Incident occurring on 2/7/2019 involving youth [redacted]

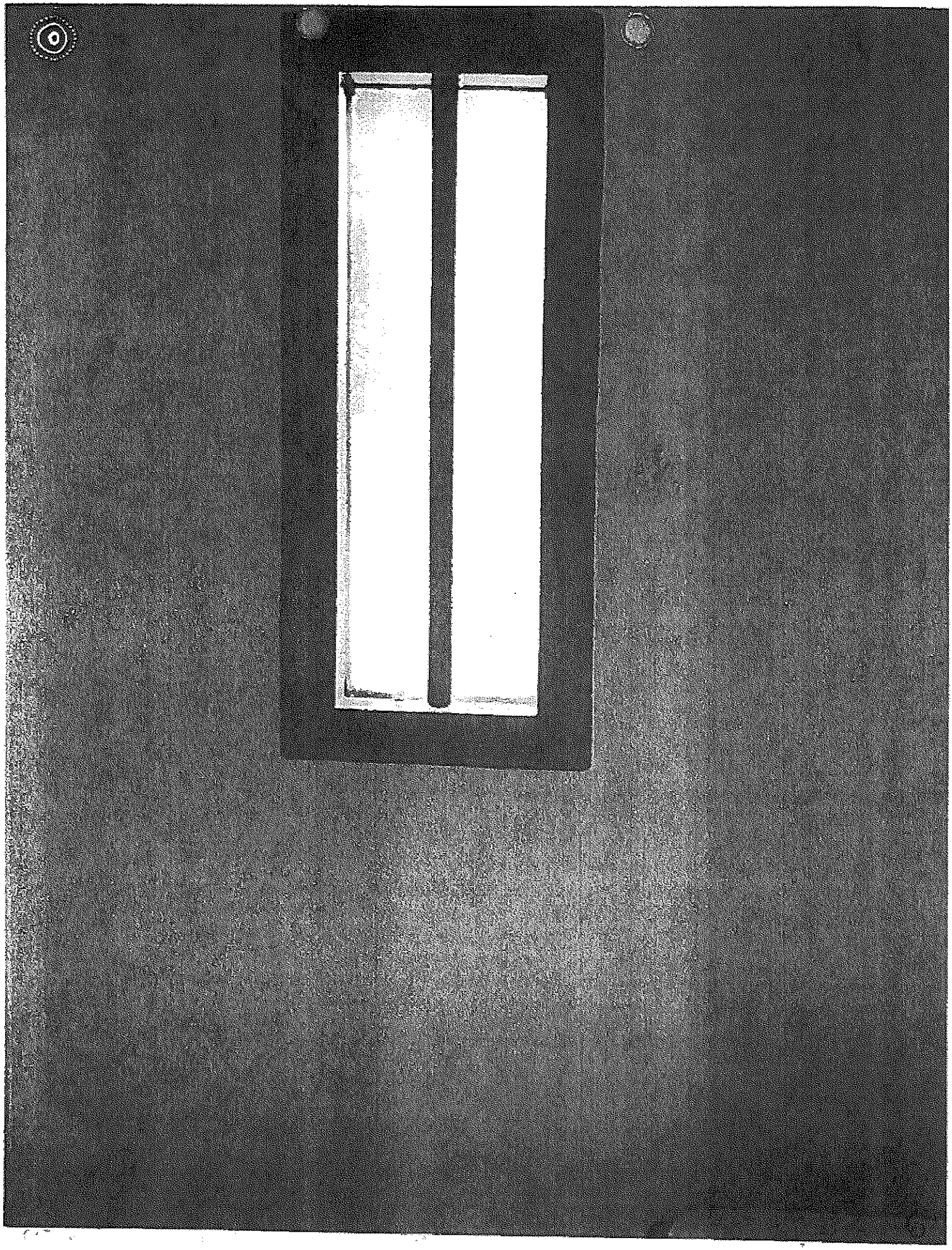
Ms. Staci Scott notified DCFS Licensing on 2/8/2019 at 8:56am regarding an attempted suicide at the facility on last night 2/7/2019 at 11:45pm. Ms. Scott submitted to me a signed, dated incident report, documentation of required 15 minute checks and a list of staff present during the time of the incident. She also provided a picture of the cell where [redacted] resided to include the window inside the cell. Per review of the information, all appropriate notifications were made to responsible parties, law enforcement, child protection, etc. There were adequate staff present during the time of the incident and supervisory checks were conducted as required as per review of the documentation provided.

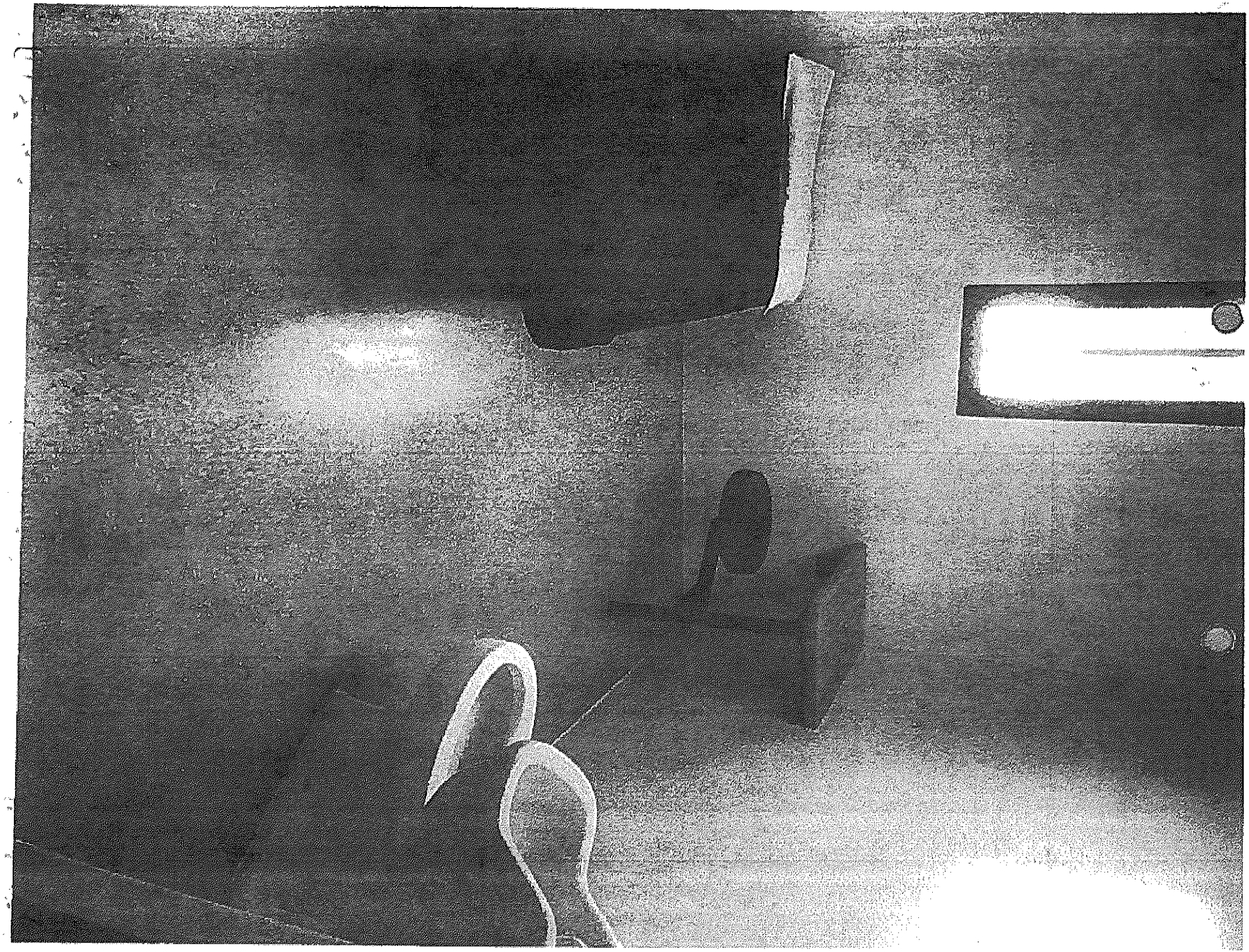
I questioned Staci Scott on 2/8/2019 about the bar on the window that the sheet was tied around. She indicated that the bar holds the window in place and there is not usually a space in between the bar and the window to stick a sheet through. Ms. Scott indicated that there is usually a weather strip behind the bar that makes it a snug fit but she thinks [redacted] removed the strip in order to create enough space for a sheet to go through. He then tied the other end of the sheet around his neck and leaned forward to cut off circulation. Ms. Scott advised that [redacted] was still alive with a faint pulse when staff found him at 11:45pm and they immediately began CPR until EMS arrived. [redacted] was transported to the hospital where he was pronounced dead. Ms. Scott advised that the Sheriff's office was coming back to the facility on 2/8/2019 to finish up interviews. I requested a copy of the sheriff's office final report when received. Ms. Scott voiced understanding.

Joy Legaux

Licensing Supervisor







CCWI CCWI CCWI CCWI CCWI CCWI 2-7-77
Horton Hummons, J. Plummer, Coleman, L. Plummer, Dempsey Thursday
6 A.M.-6 P.M.

26 males 5 females

2[00] Census check complete
2[15] Census check complete Tesato S.D. on site N/A
2[30] Census check complete
2[45] Census check complete
3[00] Census check complete
3[10] [illegible] family on site
3[15] Census check complete
3[30] Census check complete
3[45] Census check complete
4[00] Census check complete
4[10] [illegible] family off-site
4[15] Census check complete
4[30] Census check complete
4[45] Census check complete
5[00] Census check complete Supper served to all juveniles, lockdown and staff
5[15] Census check complete Supper continue
5[30] Census check complete Supper complete all trays and utensils are returned to kitchen
5[45] Census check complete Mr. John off-site
6[00] Census check complete Logbook, Key info passed. Mr. Horton does a population count on 26 males and 6 females all 32 are used for Shift End

CCWII CCWI CCWI CCWI 2/7/19 [redacted]
Howard Jones Cole Demery Thurs.
Lopera

26 males 6 females

600 Census Check complete logbook, keys, info & radios passed. 26 males 6 females. 32 juv. acct for.
615 Census Check complete
630 Census Check complete
645 Census Check complete
700 Census Check complete
715 Census Check complete
730 Census Check complete
745 Census Check complete
800 Census Check complete
815 Census Check complete
830 Census Check complete
845 Census Check complete
900 Census Check complete
915 Census Check complete
930 Census Check complete
945 Census Check complete
1000 Census Check complete
1015 Census Check complete
1030 Census Check complete
1045 Census Check complete
1100 Census Check complete
1115 Census Check complete
1130 Census Check complete
* 1145 Census Check complete Jones calls 911 *
1200 Census Check complete 911 on site & Sheriffs on site
1215 Census Check complete 911 off site with juv.
1230 Census Check complete Nurse Melanie on site

CCW1 CCW1 CCW1 CCW1 CCW1 CCW1 CCW1
Howard Jones Cole Demery Horton Thurs L Newman
Upton

24 males 6 females

1245 Census Check complete 7 Sheriff offsite Mr. Rayford
100 Census Check complete 2 Sheriff onsite
115 Census Check complete
130 Census Check complete Ms. Lamenda B Horton on site
145 Census check complete
200 Census Check complete
215 Census check complete
230 Census Check complete
245 Census check complete
300 Census Check complete
315 Census Check complete
330 Census Check complete
345 Census check complete
400 Census check complete
415 Census Check complete
430 Census Check complete
445 Census Check complete
500 Census Check complete
515 Census Check complete
530 Census Check complete
545 Census Check complete
600 Census Check complete logbook, Keys, info B
radios passed. 25 males & females accet for.
32 juveniles present

K note

The above notation showed state 25 males
6 females accounted for. 31 juveniles present
Juvenile [redacted] was transferred to
the ER after suicide attempt where he was
pronounced deceased on 2/8/19. (SS)

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
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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.*

4

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)

- 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 -
C2 -

Staff Identifier
S1—Staci Scott

Director's Initials: _____

INCIDENT SECTION

1. Was proper Reporting procedure followed?

As noted in the incident report, G1 was found tied to his chest hanging from the top door hinge by S3 when he was conducting the 11:30pm visual check. S3 and S6 stated G1 was in a holding cell that night and had been since 2/9/19 because G1 had been successful at breaking the lock in the cell in which he was normally housed. These 2 staff also stated there was no private cell which G1 was to be moved back to the normal cell. As observed by investigator, the holding cell has a door which opens to the inside of the cell. The inside of the door is held by 3 hinges. The top one is located about 4 inches from the top of the door. Also as observed by investigator, this top hinge has a slit located on the inside of the hinge. It is about 1/8 to 1/16 inches wide. Also on the inside top of the hinge, the noted slit does not go all the way down. It comes to a point when the top section of the hinge rounds the next section. As a result of this, the slit can hold whatever is placed in it, but does not appear to go all the way through. While at the facility, a detective from the Red River Sheriff's Office was also present and he observed and took a picture of the side of the cell immediately following the incident. On the picture, specialist observed the sheet threaded in the noted slit, held up by the hinge, and hanging down with a make shift noose.

Specialist then examined the video on the matter. The video is an observation of the outside of the holding cell door. There are no videos on the inside of the cell, nor is there any audio available. The video footage is able to show if any staff went by the cell to conduct a visual check, but due to the distance of the camera from the cell and limited lighting, conducting clarity is lacking. As noted, a visual check was done at 11:30pm to find the deceased as noted. Therefore, specialist examined the video footage for the 15 minute time slots prior to this to determine if staff acted in accordance with Licensing regulations. As observed by specialist, this video system only records when there is movement, and per the observed video, the last time there was movement in this space prior to the incident was 10:45pm. Due to this, per the video, there was no visual check done of this resident while in the holding cell during either the 11pm or 11:15pm visual check times by any facility staff member. Regarding the 10:45pm notation, staff member S7 (as noted by S1), from the video footage, was observed walking past this cell/room 2 cell multiple times, never stopping at the door at any point. S1 stated S7 was usually greeting all residents and was found to get 'out of the facility by control'. S1 stated S7 decided to not be tasked to the residents at one point while passing by. There is no audio available, therefore, there was no available evidence to verify this.

Assuming a proper visual check was not completed by S7 at this time, specialist examined more video to see when the last timely, clear and obvious visual check was done by a staff member of G1 while in the holding cell. Per the video that occurred at 9:15pm. Therefore, no visual check was done by any staff member of G1 for the required visual checks at/prior to 9:30, 9:45pm, 10pm, 10:15pm, 10:30pm, 10:45pm, 11pm or 11:15pm. Licensing requires staff to be observed on video footage for these times and observed that G1 was not properly checked by a staff person at least every 15 minutes as provider's documentation declares and procedure requires.

NOTE: The facility has documentation provided by staff that says visual checks were done at all required times leading up to the incident. Per the documentation, all residents, males and females, were noted as having been checked on in a timely manner. As noted, the video footage does not support these documents.

Specialist then examined G1's file. As mentioned by S5 and S6, there was no documentation G1 has ever been on suicide watch while at the facility. G1 was admitted to the facility on 2/7/19, there was no mention by facility staff who was conducting the mental screening at intake of any suicidal concerns for G1. Due to this, the facility was required to complete a full mental health assessment within 72 hours from intake, per the facility documentation. This assessment was not done until 2/8/19. At this, specialist examined whether or not the mental health assessments were done timely for other residents. Specialist examined 29 designated folders, 27 were discovered that 18 of the 29 failed to be completed within the 72 hour requirement. It was discovered some were completed as late as one day past requirement all the way up to 26 days past requirement. It should also be noted the facility has 3 residents who transferred from their residential licensed facility to this detention facility who did not receive either a full or updated mental health assessment when being admitted to this detention center. S1 stated the residents have the same information when transferring from their residential to detention centers. Therefore, S1 stated she thought a new assessment was not necessary.

Ware Youth Center - Coushatta
9565 Highway 1
Coushatta, LA 71019

Date - 02/12/2019
License # - [illegible]
Action Code - 23

2. What action was taken by provider to ensure incident does not occur again?

Per S1 and S2, the facility has taken several steps and is in the thought process of attempting to do other things to ensure this does not happen again.
1.) The facility, for non-suicide watch, has a policy the minimum requirements of 15 minute room checks for each detainee while in a cell. As of the moment, each detainee will be on 5 minute room check. S2 stated this is temporary for now, and he is not sure when this will change. He added, he will be recommending to his board at their next meeting, changing to 10 minute room checks for non-suicide detainees.
2.) All detainees are currently dressed in shorts and t-shirts while inside the facility. S2 stated this prevents a large amount of fabric available to the residents to use for suicidal purposes. He stated this will change back to the norm with pants and long sleeve shirts when it has been determined okay to do so.
3.) All detainees have had their pillowcases and thin sheets removed from their cells. The detainees will only use a thick wool blanket at night for cover. S2 stated the wool blanket is too thick to use in a suicidal way as done in this incident with the thin pillowcase and sheet. S2 stated they will go back to the pillowcases and sheets once they deem it is okay to do so.
4.) The day after the incident, all residents were reassessed by a facility counselor. S1 stated no resident has asked to speak with a psychologist as a result of this incident.
5.) A suicide specialized social worker is being called in to meet with facility staff to help further educate them on this topic and talk to any staff who may need counseling as a result of the incident. S2 stated if any resident feels the need to talk to this person, they will have this happen as well.
6.) They have contacted the manufacture of the facility regarding what can be done regarding the construction of the door to prevent this from happening again. S2 stated they have yet to return the facility's phone calls.
7.) Regarding the hinge where the sheet was tied, S2 stated they are looking into welding a piece of metal on top the [illegible] which would prevent any fabric from entering the slitted space and holding said fabric.

3. Has staff been properly trained?

Per S1 and facility documentation, the 2 staff assigned to the space where the incident occurred was staff supervisor S3 and direct care worker S4.
Per facility documentation, S3 was hired on 12/10/14, and he completed his annual training with all required licensing topics on [illegible].
Per facility documentation, S4 was hired on 8/13/18, and he completed his orientation training on all required licensing topics on [illegible].
Per facility documentation, both staff responsible for conducting visual checks of D1 while in the holding cell were considered to be properly trained prior to the incident.

4. Has staff involved been terminated or re-trained?

Per S1, neither S3 nor S4 have been terminated at this point. S1 stated, they have been unable to contact S3. She stated S3 has not come back to work since the incident, and he has not returned any of their calls. S1 stated they have been told from other staff that S3 stated he was not going to come back, but they have not received any official word from S3. Regarding S4, S2 stated S4 is on paid administrative leave pending the result of the investigation into the incident.
If either or both S3 and S4 come back to work at the facility, S1 and S2 stated each will receive a re-training on room check policy and procedures, suicide prevention, as well as other licensing topics in which they are already due for re-training.

[Signature]
[illegible] Signature

2/22/19
Date

[Signature]
2/22/19

Ware Youth Center - Coushatta
3565 Highway 71
Coushatta, LA 71019

Date - 02/12/2019
License # - 15596
Action Code - 23

Personnel Worksheet

Staff Identifier	Staff's Name	Staff Presence	Hours/Days Worked	
S1	Staci Scott			
S2	Joey Cox			
S3	Jhanquial Smith			
S4	Marvin Rogers			
S5	Lamonda Newman			
S6	Jeremy Horton			
S7	Travis Howard			

NAME:									
Criminal Background Check									
7511.C.1 Health Screening									
7511.B.1-3 Criminal Background Clearance									
7511.D.1 Performance Reviews									
7511.H.1.a Personnel Files - Application/resume of education, training, & experience									
Hire Date/Termination Date									
Current Drivers License									
specific responsibilities of assigned job duties									
7511.F.2.a Orientation philosophy, organization, program, practices and goals of the facility									
administrative procedures									
emergency and safety procedures including medical emergencies									
youth's rights									
detecting and reporting suspected abuse and neglect									
infection control to include blood borne pathogens									
confidentiality;									
reporting of incidents									
intake to include classification procedures and release									

Ware Youth Center - Coushatta
3565 Highway 71
Coushatta, LA 71019

Date - 02/12/2019
License # - 15596
Action Code - 23

Children's Record Worksheet

Child Identifier	Child's Name	Child's Date of Birth	
C1	[redacted]		
C2	[redacted]		

NAME:									
7511.H.2.a Youth Files : Youth's Name									
Youth's DOB									
Youth's SS#									
Youth's previous address									
sex of Youth									
Youth's religion									
Youth's birthplace									
Date of Admission/Date of Discharge									
Other identification data/court status/ legal status/legal custody/authorized to give consent									
Name/Address/Tele# of legal guardian/ parent									
Name/Address/Tele# of a physician & dentist									
pre-admission assessment and admission assessment									
youth's history - family data/Educational background/Employment record/Prior medical history/Prior placement history									
physical assessment report									
continuing record of any illness/Injury/ Medical or dental care									
reports of incidents of Abuse/Neglect/ Incidents- including use of time out/ Personal restraints/Seclusion									
summary of releases from the facility									
summary of court visits									
summary of all visitors/Contacts including dates/Name/Relationship/Tele#/Address/ Nature of Visits/Contacts/Feedback from the family									
record of all personal property/Funds entrusted to provider									
reports youth grievances/Conclusion/ Disposition of these reports									

Joy A. Legaux

From: Joy A. Legaux
Sent: Tuesday, February 12, 2019 8:19 AM
To: 'Staci Scott'
Cc: Angie Badeaux
Subject: FW: [redacted] Incident 2/09/2019

Good Morning Ms. Scott

Your explanation of why checks were documented for 11pm and 11:15 (even though they were not done for that particular cell) needs to be included on the list of checks provided because what is documented contradicts your incident report. Please sign and date the updated list and resubmit also. Thanks

From: Staci Scott <staciscott@wareyouthcenter.com>
Sent: Monday, February 11, 2019 5:25 PM
To: Joy A. Legaux <Joy.Legaux.DCFS@LA.GOV>
Subject: RE: [redacted] Incident 2/09/2019

There were checks done everywhere but the location where that juvenile was in the holding cell. We are under the impression that one staff thought the other staff was checking this area. The report should read 2/09/19. I will retype it and resend.

Thanks,
Staci

From: Joy A. Legaux [mailto:Joy.Legaux.DCFS@LA.GOV]
Sent: Monday, February 11, 2019 4:26 PM
To: 'Staci Scott'; Angie Badeaux
Cc: Angie Badeaux
Subject: RE: [redacted] Incident 2/09/2019

Ms. Scott

Per review of the information, you advised that no room check was done at 11pm or 11:15pm yet there are checks for these times documented on the list provided. Also, the date of the incident on your typed incident report denotes 2/7/19. Is this supposed to be 2/9/19? Please clarify these matters! Thanks

From: Staci Scott <staciscott@wareyouthcenter.com>
Sent: Monday, February 11, 2019 1:58 PM
To: Joy A. Legaux <Joy.Legaux.DCFS@LA.GOV>; Angie Badeaux <Angie.Badeaux.DCFS@LA.GOV>
Subject: [redacted] Incident 2/09/2019

Ms. Angie and Ms. Joy,

Please find attached the requested documents from the incident on 2/09/2019. I texted the pictures already.

Thanks,
Staci

incident #2

7

Smith Howard Davis Rogers (S) 2/8/19

6pm-6am ~~Fri~~ Sat

26 males 6 Females

7:30 Census Check Complete
7:45 Census Check Complete
8:00 Census Check Complete
8:15 Census Check Complete
8:45 Census Check Complete
9:00 Census Check Complete
9:15 Census Check Complete
9:30 Census Check Complete
9:45 Census Check Complete
10:00 Census Check Complete
10:15 Census Check Complete
10:30 Census Check Complete
10:45 Census Check Complete ~~Howard offsite~~
11:00 Census Check Complete
11:15 Census Check Complete
11:30 Census Check Complete RRSO onsite
11:45 Census Check Complete
12:00 Census Check Complete
12:15 Census Check Complete Lamonch onsite
12:30 Census Check Complete
12:40 Mr. Cox onsite
12:45 Census Check Complete
12:48 RRSO offsite
12:51 Mrs. Brown onsite

4E 11:30 While conducting 11:30pm room check, juvenile [redacted] was found with a sheet tied around his neck. Shift supervisor Shanquale Smith removed the sheet & immediately began CPR until EMS arrived. EMS arrived & transported to Christus Coushatta ER where he was pronounced deceased. (SS)

cont Smith-Howard-Davis-Rogers 2/7/19
4pm-6am Sgt

(26) males (6) Females

4E Note * Census checks were conducted in Dayrooms A, B, C & D for 11:00pm - 11:15pm. Staff did not make the required room check on the Holding cell for 11:00pm - 11:15pm (SS)
Staci Scott 2/12/19

Ware Youth Center Detention Center	Policy Number 10.14 Pages 2
Chapter: Security and Control Subject: Room Checks	Related Standards:

I. **POLICY**

Room checks shall be conducted anytime a juvenile is in his/her room. Room checks shall be done according to established procedures.

II. **DEFINITIONS**

None.

III. **PROCEDURES**

A. Room Checks:

1. When a juvenile is in his/her room, staff shall conduct a room check at least every 15 minutes.

2. When conducting a room check staff shall either (if dark) turn on the night-light or use the flashlight to look into the room. Staff must observe the juvenile before going to the next room.

3. After completing the room checks in the area, staff will scan their security card in front of the Door King Manager ensuring the red light turns to green when scanned.

4. After conducting the checks staff shall record the time of the checks in the logbook.

B. Security Cards:

1. Upon employment each Childcare worker shall be given a security card.

2. An employee's security card shall not be given to another employee for use. This is a vital part of the documentation system and shall be treated as such.

3. Employee's found allowing other employee's to use their card may be suspended or terminated.

4. If the security card is lost or stolen, it must be immediately reported to the Program Manager who will notify the Director.

5. Upon resignation or termination of the staff's position, he/she must turn in the security card to the Program Manager.

6. A $25 charge will be deducted from staff member's paychecks for all lost or not returned cards.

C. Security Cameras:

1. The monitor for the security cameras in the staff station shall be maintained as to allow for the maximum viewing of all security cameras. If there is an emergency or a situation that needs staff attention staff can pull the area to full screen or to position that best allows for viewing then return the cameras to the maximum viewing possibilities.

2. The Director shall be responsible for recording all pictures on the camera 24 hours a day.

3. The Director shall keep on file the VCR tapes for at least 30 days.

4. Any intentional alteration of the video signal, as to not allow for viewing, result in immediate termination.

Effective Date:	Approved By:	Date Revised:
4-5-11		11-1-11

Ware Youth Center
Incident Report

Name of Person Filing Report: [redacted] Date of Report: 2/11/2019

Name of Persons Involved: [redacted] Juvenile
Jhanquail Smith – Shift Supervisor
Marvin Rogers – Childcare Worker I
Kayla Davis – Childcare Worker I

Date of Incident: 2/09/2019 Time of Incident: 11:30 p.m.

Location of Incident: Holding Cell 1

Nature of Incident: While making the 11:30 p.m. room check, Shift Supervisor Jhanquail Smith found juvenile [redacted]. with one end of a bed sheet tied to the door hinge of his room and the other end tied around his neck. [redacted] was unresponsive. Shift Supervisor Smith and Childcare Worker I Marvin Rogers began CPR until EMS arrived. EMS arrived and took over care of [redacted] transporting him to Christus Coushatta Emergency room where he was pronounced deceased.

Action Taken: Shift Supervisor Jhanquail Smith and Childcare Worker I Marvin Rogers untied the sheet from around [redacted] neck and began CPR until EMS arrived. The Red River Parish Sheriff's Office also began their investigation into the incident. I made a mandated report to DCFS and also completed a Critical Incident Report to DCFS Licensing.

Staff Interviews:

Jhanquail Smith: I was unable to speak to Shift Supervisor Jhanquail Smith. He was upset and went home after the incident. He did not write an incident report and staff has been unable to make contact with him since.

Kayla Davis: I spoke to Kayla Davis who stated when Shift Supervisor Jhanquail Smith made his 11:30 p.m. room check on [redacted], he found [redacted] with a sheet tied around his neck and the other end attached to the door hinge. Shift Supervisor Smith instructed Davis to call 911. Davis advised Shift Supervisor Smith and Childcare Worker I Rogers began CPR on [redacted] until EMS and Red River Parish Sheriff's Office arrived.

Marvin Rogers: Marvin was very distraught and unable to talk after the incident. However, he did write an incident report (see attached).

Rose Marie Salim (LCSW): I spoke to Rose Marie Salim, LCSW on Sunday, February 10th. Rose Marie stated that she had spoken with [redacted] on Friday, February 8th for approximately 1 hour. Rose Marie stated [redacted] was curious about the incident on the previous night but did not voice any suicidal ideations. Rose Marie stated [redacted] was joking and in a good mood.

Video Review: During the review of the video, I concluded that Childcare Worker II Travis Howard (Howard confirmed) was last seen talking to [redacted] at 10:45 p.m. when he was leaving for the night. Staff did not conduct a room check on [redacted] at 11:00 p.m. or 11:15 p.m. [redacted] was found during the 11:30 p.m. room check.

Notifications:

Joey Cox – Director
Raymond Lloyd – Program Manager
Melanie Hearold – Nurse
Lt. David Hensley – Red River Parish Sheriff's Office
Rose Marie Salim – Case Manager
Sandra Brown – Case Manager
DCFS Intake Hotline – Tinesha Hudson (Intake # [redacted])
DCFS Licensing
Parent (Notification made by the Assistant Coroner Janelle Thomley)

[redacted]

2/11/19
Date

6-3-09 DS

INCIDENT REPORT
(PLEASE PRINT OR TYPE)

NAME OF PERSON FILING REPORT: Marvin Rogers **DATE OF REPORT:** 2-9-19

NAME OF ALL PERSONS INVOLVED: Marvin Rogers CCWT
Kayla Davis CCWT
Jarquial Smith CCWT

DATE OF INCIDENT: 2-9-19 **TIME OF INCIDENT:** 17:30 AM/PM

LOCATION OF INCIDENT: Holding Cell #2

Each staff member directly or indirectly involved in the incident should file a separate incident report. Do not collaborate in writing one report. Try to answer in your report the who, what, where, when and why questions: be objective in your statements.

NATURE OF INCIDENT: I, Marvin Rogers (CCWT) was called to holding cell by Kayla Davis (CCWT) to assist Jarquial Smith (CCWT) with the Juvenile when I made it to holding cell #2 the Juvenile was laying on his back receiving cpr from Jarquial Smith (CCWT); we began to switch doing cpr

TYPE OF INCIDENT

RESIDENT-ON-RESIDENT ASSAULT		RESIDENT-ON-STAFF ASSAULT	
SUBSTANCE RELATED		PROPERTY EVENT	
SEXUAL MISCONDUCT		POSSESSION OF CONTRABAND	
SELF HARM		SUICIDE	X
PERSONAL INJURY		OTHER	

ACTION TAKEN: Call 911 Raymond Lloyd, CPR

RESULTS OF ACTION:

YOUR OPINION AS TO WHY THE INCIDENT TOOK PLACE: Unknown

Use Incident Report Supplement for other or additional information.

SUPPLEMENTAL PAGES ATTACHED? V YES ____ NO

SIGNATURE OF STAFF COMPLETING REPORT: Marvin Rogers

SIGNATURE OF SHIFT SUPERVISOR: RN

INCIDENT REPORT SUPPLEMENT

until paramedic arrived.

end of report

2-9-19

Marcia Rodgers

19/irs.frm/ml

6-3-09 DS

INCIDENT REPORT
(PLEASE PRINT OR TYPE)

NAME OF PERSON FILING REPORT: Kayla Davis **DATE OF REPORT:** 2/9/19

NAME OF ALL PERSONS INVOLVED: Kayla Davis (CCWII)
Tiffanie Rogers (CCWII)
Thomas J. Smith (CCWII)
[redacted] - Juvenile

DATE OF INCIDENT: 2/9/19 **TIME OF INCIDENT:** 1130 **AM/PM**

LOCATION OF INCIDENT: Holding Cell #2

Each staff member directly or indirectly involved in the incident should file a separate incident report. Do not collaborate in writing one report. Try to answer in your report the who, what, where, when and why questions: be objective in your statements.

NATURE OF INCIDENT: Approximately at 11:24 - [redacted] called the facility to see how everything was going. She then asked was everybody doing their fifteen minute checks. I Kayla Davis replied yes ma'am. Proceeding on 11:30 pm check. CCWII Mr. Smith checked. Pod and walked to holding cell #2 and found juvenile [redacted] unresponsive. CCWII

TYPE OF INCIDENT

RESIDENT-ON-RESIDENT ASSAULT		RESIDENT-ON-STAFF ASSAULT	
SUBSTANCE RELATED		PROPERTY EVENT	
SEXUAL MISCONDUCT		POSSESSION OF CONTRABAND	
SELF HARM		SUICIDE	X
PERSONAL INJURY		OTHER	

ACTION TAKEN: 911 was called and [redacted] was notified of the incident.

RESULTS OF ACTION:

YOUR OPINION AS TO WHY THE INCIDENT TOOK PLACE:

Use Incident Report Supplement for other or additional information.

SUPPLEMENTAL PAGES ATTACHED? ✓ **YES** ___ **NO**

SIGNATURE OF STAFF COMPLETING REPORT: Kayla

SIGNATURE OF SHIFT SUPERVISOR: [redacted]

INCIDENT REPORT SUPPLEMENT

Page ___ of ___

Mr. Smith yelled and said called "911". CCWI Mrs Kayla ranned to the holding cell and to see what was wrong. Al CCWI Mrs. Kayla called CCWI M. Rogers to help assit with then juvenile. Al Kayla Davis call "911" about the incident While CCWII J. Smith and CCWI M. Rogers continued doing CPR on Juvenile [illegible]

19/irs.frm/ml

https://www.ktbs.com/news/teens-commit-suicide-at-ware-youth-center/article_e6e9fcd8-2e2c-11e9-89f5-b7259a240088.html

2 teens commit suicide at Ware Youth Center

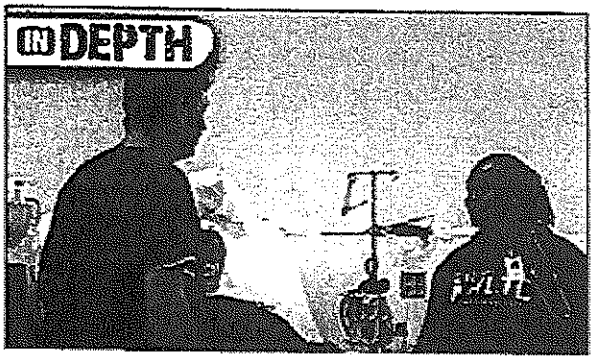
Vickie Welborn Feb 11, 2019 Updated 17 hrs ago

Ware Youth Center.

Two teenage offenders held in Ware Youth Center in Red River Parish committed suicide within a 72-hour period in recent days, authorities said.

Red River Parish sheriff's investigators are looking into the circumstances of the 17-year-old's death Thursday night and 13-year-old's death Saturday night. Both teens hanged themselves with bed sheets, authorities said.

Red River Parish Sheriff Glen Edwards his initial information indicates the deaths are not connected and no foul play is involved.



"There doesn't seem to be a connection," Edwards said. "It's just a terrible, terrible coincidence."

Because the deaths are believed to be suicides, the names of the teens are not being made public.

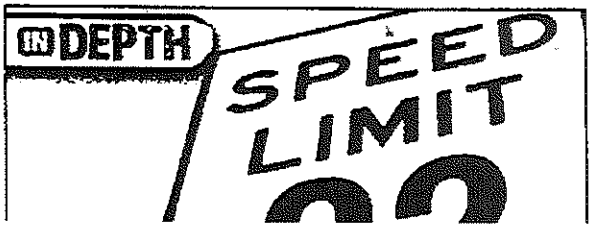
"As is customary to any incident of this nature, it is currently under investigation by the authorities," Ware Executive Director Joey Cox said in a statement to KTBS News. "Our thoughts and prayers are with both of these young men and their families and friends during this difficult time."

Both teens were sent to Ware following their arrests in Bossier Parish, which is among the parishes who use Ware because they do not have a juvenile detention center.

The 17-year-old, who had recently moved to Bossier Parish from Colorado, had been arrested after he got involved in an argument with a friend in his front yard after being accused of stealing money. The teenager reportedly had a pistol in his belt. Bossier Parish sheriff's deputies were called and arrested the teenager, who escaped from the back seat of a patrol unit as a deputy questioned witnesses.

A K-9 was brought in to search the area and the teenager was eventually located in a nearby bayou. A 9mm handgun was recovered. The teen was arrested for simple escape and resisting arrest and taken to Ware until his court date.

He was checked on at 11 p.m. and nothing unusual was noted. A guard returned 15 minutes later to find the teen hanging from a sheet.



The 13-year-old, whose birthday was Jan. 20, was detained early this month on a charge of simple arson. Authorities said he set toilet paper on fire at a Haughton Middle School restroom.

During a court hearing on Feb. 4, a letter was issued seeking a psychiatric evaluation to be completed on or before March 11. It's uncertain what prompted the request.

The young teen was pronounced dead at the hospital in Coushatta.

Interviews with Ware staff and video surveillance will be used in the investigation, Edwards said. The goal also is help Ware officials understand what happened and put measures in place to prevent it from happening again.

The sheriff doesn't have a timeline on how long the investigation will take. The completed report will be submitted to the Red River Parish District Attorney's Office for review.

Ware is a state-created juvenile detention facility that's operated by a board of directors from parishes that fund its operation. It is approved by the state Office of Juvenile Justice to house pretrial and post-conviction juvenile offenders.

The last suicide reported at Ware happened in March 2017 when a 16-year-old girl from Lake Charles was found hanging from a bed sheet in her dorm room.