Youth treated like animals at Wayne County juvenile detention center

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In December 2023, Tanzy Huddleston and Shermanstine Morrow, former nurses for Wayne County, filed a lawsuit against Wayne County, its executive Warren Evans, and Melissa Fernandez, county director of Juvenile and Youth Services and the chief administrator of the Wayne County Juvenile Detention Facility (JDF).

Huddleston and Morrow claim that they were fired as retaliation for exposing deplorable conditions that exist at the facility. According to Wayne County's website, the detention facility houses youth who are "awaiting adjudication after being charged with a crime and/or while awaiting a residential placement after adjudication."

Due to the conditions revealed by Huddleston and Morrow and by an investigation by Michigan's Division of Child Welfare Licensing (DCWL) in March and April 2023, the Juvenile Detention Facility is currently operating on a six-month provisional license. During this period, the Michigan Department of Health and Human Services (MDHHS) is observing the facility 24/7. Afterwards, MDHHS will either upgrade their license or revoke it.

Huddleston, Morrow, and the state investigation reveal that the residents are regularly treated like animals. The youth at the facility, many with emotional and behavioral problems, need a safe and supportive environment to overcome their problems. Instead they are treated like criminals and exposed to abuse. For exposing these conditions, Huddleston and Morrow have suffered threats, firing, loss of income, and loss of reputation.

The facility also suffers from the broader crisis facing healthcare worldwide: perpetual short staffing. Healthcare workers around the world are facing overwork and attacks on wages and benefits, causing burnout, with many leaving the profession.

Wayne County hired Huddleston as a Licensed Practical Nurse (LPN) and Morrow as a Registered Nurse (RN) in March 2023. Huddleston and Morrow say that their supervisor, Dr. Carla Scott, started to harass and threaten them after the two began exposing dangerous and potentially deadly conditions at the facility.

Huddleston observed on March 20, 2023 that the only records being kept about medications and treatments given to the young residents were on loose paper. Medical staff are required to record this information in the electronic Medication Administration Record (MAR) system, which prevents tampering with records. The DCWL investigation confirmed that a full week of MAR records was nonexistent for at least one resident, who alleged he did not receive his psychiatric medicine during his first three weeks there. Huddleston also discovered that some of the medication being distributed was expired, and reported these violations to Dr. Scott.

In April, Morrow began filing formal written complaints because the tools on the facility's crash carts looked moldy. She further noted that vital tools on the cart were expired: one cart contained an EpiPen that had expired three years prior, and a blood glucose meter that had expired two years before. She showed these things to Dr. Scott and office manager Kim Heard, as well as pointing out that the contents checklist had not been updated for nearly two years.

According to the lawsuit, Dr. Scott was not upset at the violations, which could result in fraud, serious bodily injury to residents, or even death, but rather at the fact that Huddleston and Morrow were reporting them. She allegedly threatened Morrow, telling her that she "had never had anyone come and oversee how she ran a facility until Plaintiff Morrow spoke out."

Dr. Scott retaliated against their exposure of these conditions, and threatened to fire Huddleston and Morrow. She suggested they should instead quit, and menacingly told them of how she had previously fought hard to get a former employee's unemployment benefits denied.

The lawsuit also details other violations which Huddleston and Morrow witnessed. On June 20, Huddleston saw and photographed prescription medication left out in the open. Huddleston and Morrow both observed separate incidents where different nurses distributed to newly arrived youth the medications which had been prescribed to former residents.

In another instance, Huddleston reports covering for one of Dr. Scott's favorites, a nurse named Dozier. When Huddleston informed Dozier that there was a resident who could not breathe and had chest pains, Dozier told her that he would get another nurse to respond to the situation. After Dozier failed to do this, Huddleston took care of the young man herself. When she confronted Dozier, he allegedly replied, "I'm tired of these miserable motherfuckers," referring to the young people at the facility.

This culture of neglect by the administration, retaliation against those who speak out, and intense employee burnout illuminates the attitude of the state toward the young residents. They come and go as their cases are decided, with no one examining the social conditions under which youth commit crimes. There is an

undeniable link between grinding poverty, the defunding of schools and after-school programs, and living in a country that has been at war for decades, and where young people find their road to a decent future blocked. The capitalist system considers all young people who need extra help as criminals to be locked away.

The deplorable conditions which exist at the Juvenile Detention Facility are well known to Wayne County and the state of Michigan. The facility was the subject of seven separate licensing investigations before county and state officials got involved. This happened only after a youth reported being sexually assaulted at the facility. It was at this point that Wayne County Executive Warren Evans declared a public health emergency order, describing the situation as "untenable" for the 140 juveniles being housed there.

For the state investigation, Michigan's DCWL brought in Child Welfare Licensing Consultant Venus Decker, who led it, along with at least two MDHHS workers. The conditions which Decker and her team discovered inside the Juvenile Detention Facility are deeply disturbing and horrifying.

They found many residents' rooms piled up with trash from meals which had not been removed. The facility is split into several units which they call "pods," each of which contains up to 60 rooms. In Pod C, Decker found dried feces smeared on the walls and in the vent of one room on her first inspection. An administrator promised to fix the problem, but when she found the same thing at the next inspection, she learned that the "fix" was to provide the room's resident with gloves and a spray bottle. She demanded again on March 30 that they clean the wall, but when she returned on April 20, it was in the same condition.

Decker further found that the facility does not regularly supply the young people under their care with basic hygiene supplies such as toothbrushes, toothpaste, soap and deodorant. When residents ask for these things, some are given travel-sized items but, once these run out, they have to wait for another shipment. When Decker asked that these things be provided, staff explained that there was nothing in the supply closets to give, as management did not order enough. In one pod, which Decker inspected personally, she found that 27 of the 36 youths did not have toothpaste.

At one point, an administrator emailed Decker promising her that they would acquire and hand out hygiene kits, having residents initial a roster to show receipt. Despite two requests for the rosters, the facility never provided them.

They also do not provide regular access to showers. Many youth told Decker that they would sometimes have to go up to two weeks without a shower. The facility handed over its Daily Activity Schedule for two pods from March. These revealed that the opportunity to shower is only offered sporadically, and to only a few people at a time. Despite proportions as low as 2 percent (1 out of 50) to 8 percent (5 out of 60) getting a shower, only three people are recorded as refusing a shower between the two pods over this period.

The state investigation also discovered instances of collective punishment. To receive a license, facilities must submit a Temporary Disaster Plan to be implemented if a resident is noncompliant. The JDF regularly violates the plan it filed with the state. If a single resident acts out, they deny recreation time to everyone, and will delay meals for hours at a time. In several cases, staff and residents reported not receiving breakfast because of the behavior of a few.

In one particularly chilling instance, a doctor told investigators that the facility withheld an entire pod's medications, forcing everyone to miss a dose. Showing their utter contempt for the state and expectation of impunity, the facility had added an allowance for withholding medicine to its disaster plan, without informing the state.

The facility also does not provide its residents with clean clothes on a regular basis. Decker found multiple instances where residents had been forced to wear the same clothes, even underwear, for a week at a time. Several reported that they would wash their own clothes in the sink in their rooms. In one pod, a staff member reported that they get 25 clothing bundles (each one is a set of clothing for one person) despite having 36 young people under their care.

In a transparent attempt to influence the investigation, the room where Decker interviewed residents contained a large number of clothing bundles. One staff member confided that this was the first time she had ever seen so many in the facility.

The investigation also found that the facility was not meeting residents' medical needs. One doctor told Decker that the facility is missing six RNs and two doctors. As a result, they consistently fail to provide initial assessments of residents in a timely manner. These are supposed to be completed within 24 hours of admittance, but many residents had to wait up to five months. At the time of the investigation, Decker found that there were 22 residents who had not received one yet.

In one case, the facility failed for months to act with a youth who was experiencing intense depressive episodes. According to facility records, the youth began falling into depression on October 9, 2022. He was not transferred to a hospital until December 13, by which point he had lost 30 pounds and had not showered for four to five months. A psychiatrist ordered the youth be provided extra food and snacks, but the facility has no records to show that this ever happened.

In December 2023, Licensing Consultant Chris Barr investigated the sexual assault allegation, and found several more violations against the JDF. The youth reported being assaulted and raped, and video footage shows him being forced to stand naked on a table. When staff witnessed this, they did not immediately intervene, because they are too afraid to enter the pod unless everyone is in their rooms, the victim told Barr. Now, in January 2024, Wayne County has forced six staff members to resign, according to the *Detroit Free Press*. As of this writing, it is unclear what positions the fired workers held.