**IN THE CIRCUIT COURT OF PRINCE GEORGE'S COUNTY, MARYLAND**

**JOHN DOES (CH) 1-8,**
**JANE DOES (CH) 1-2,**

**Plaintiffs,** **Civil Action No. _____**

**vs.**

**The STATE OF MARYLAND, acting through its agencies, DEPARTMENT OF JUVENILE SERVICES, DEPARTMENT OF HEALTH (formerly DEPARTMENT OF HEALTH AND MENTAL HYGIENE), STATE DEPARTMENT OF JUVENILE SERVICES and/or DEPARTMENT OF PUBLIC WELFARE, BUREAU OF CHILD WELARE, DIVISION OF INSTITUTIONS,**

**Defendant.**

## COMPLAINT

*"If you were sort of a mad scientist who was sent to Maryland to deliberately make kids into criminals, you could hardly do any better than what's going on in Maryland's juvenile facilities. . . . You'd have to work hard to cripple kids worse than they're being crippled now."*[1]

– Vincent Schiraldi, then-executive director of the Center of Juvenile and Criminal Justice, 2001; now newly-appointed Maryland Secretary of Juvenile Services.

## INTRODUCTION

1. This case is brought by survivors of Maryland's Cheltenham Youth Detention Facility ("Cheltenham").

2. Plaintiffs are individuals who, as children, the State of Maryland ("Defendant") sent to Cheltenham. By statute and according to its own policies, Defendant was supposed to provide these children with a safe and secure environment, a place where "justice-involved" youth

[1] Todd Richissin, *Lt. Gov. is Urged to Close Teen Jail*, The Sun, Nov. 27, 2001, at 1A (*quoting* Vincent Schiraldi, Executive Dir. of the Ctr. on Juvenile & Criminal Justice), https://baltimoresun.newspapers.com/image/377763277/.

could build the foundation for more "positive outcomes" in their lives.[2] Instead, at the hands of Defendant's own employees, Plaintiffs were beaten, molested, assaulted, and raped. They were humiliated, demeaned, and psychologically coerced. They lived in squalid conditions, deprived of the basic standard of living that every child deserves. Some were as young as 11 when their living nightmares began.

3. What Defendant allowed to happen at Cheltenham is a travesty. Defendant had a legal and moral duty to protect the children entrusted to its care. And Defendant miserably failed in fulfilling that duty, standing by while its own employees subjected Plaintiffs and untold numbers of other children to horrific neglect and criminal abuse.

4. As set forth below, Defendant knew for decades that the guards and staff members at Cheltenham were engaged in wrongdoing. Over and over, the agency was put on notice that the employees they hired, retained, and were entrusted to supervise and train were seriously mistreating the children of Cheltenham. Red flags were raised; the evidence mounted. Yet, Defendant did little or nothing to investigate, expose, and stop the abusive and predatory conduct of its employees.

5. The consequences of Defendant's dereliction of its duty and violation of Plaintiffs' rights are nothing short of devastating. Plaintiffs came to Cheltenham in need of a stable environment where they could learn, develop, and grow. They deserved, and Defendant promised to provide, a chance to live a better life. Instead, because of Defendant's utter and abject failures, Plaintiffs experienced deep and lasting trauma. The effects of that trauma will be with them forever, including serious mental health conditions, emotional distress, and severe psychological issues that affect virtually every aspect of their lives, including their ability to earn income.

6. With this complaint, Plaintiffs now bravely come forward to tell their stories. They bring this suit to seek justice for the grave harms they have suffered and to expose what for decades Defendant allowed to occur at Cheltenham—a broken and corrupt institution.

[2] Sam Abed, *et al.*, *DJS 2017-2020 Strategic Plan*, Dep't of Juvenile Services, at 5 (May 23, 2017), https://djs.maryland.gov/Documents/publications/DJS-2017-Strategic-Plan-FINAL-Goals-and-Objectives.pdf.

## PLAINTIFF PARTIES

7. Plaintiffs John Does (CH) 1-8 and Jane Doe (CH) 1-2 (collectively "Plaintiffs John/Jane Doe" or "Plaintiffs") are men and women who, as children, Defendant placed at Cheltenham Youth Detention Center in Maryland's Prince George's County. Plaintiffs are now adult residents and citizens of various states.

8. Plaintiffs file this Complaint anonymously under the pseudonyms of John/Jane Does (CH) by agreement with and consent of the Attorney General of the State of Maryland. The subject matter of the lawsuit could bring embarrassment and publicity to Plaintiffs and/or their families. Plaintiffs are vulnerable to the mental or physical harms of such disclosure.

9. Plaintiffs are all persons who as minors were housed, detained, or incarcerated within Maryland's juvenile justice system at the times of the acts complained of herein. Md. Code, Cts. & Jud. Proc. § 3-8A-27 (2002) protects court records pertaining to children as confidential. Those records cannot be divulged except by order of the court upon good cause shown, or other inapplicable circumstances. Here, identification of Plaintiffs by name would automatically violate the Code and breach confidentiality.

10. Plaintiffs cannot be lawfully forced to disclose protected information as a requisite to asserting their claims for childhood sexual abuse.

11. Further, publication of the intimate and private material this case involves risks serious humiliation and embarrassment to Plaintiffs and their families. The ability to proceed by pseudonym provides some comfort and assurance as they pursue these claims. For many Plaintiffs, forced disclosure of their identities would amplify and exacerbate the injuries they have suffered. If not permitted to proceed under pseudonyms, these Plaintiffs would be forced to choose between suffering further mental and emotional harm and pursuing their legal rights.

12. Additionally, forced disclosure of Plaintiffs' identities would have a chilling effect on other similarly injured persons who are considering coming forward with their claims. Fear of

embarrassment and repercussions in their personal and professional lives may cause them to remain silent regarding their experiences.

13. The public interest in the disclosure of Plaintiffs' identities is minimal.

14. As demonstrated by the Attorney General's stipulation, Defendant would not be unduly prejudiced by allowing Plaintiffs to proceed anonymously. Any potential prejudice will be mitigated by the confidential disclosure of Plaintiffs' actual identities.

**DEFENDANT PARTIES**

15. Defendant enforces Maryland's laws through its Executive Branch, consisting of various officers and agencies as authorized by Maryland's Constitution and its laws. Defendant acts through and controls those agencies.

16. Among the laws enforced by the State of Maryland are those governing the management, supervision, and treatment of youth involved in the State's juvenile justice system.

17. From 1943 to 1966, the Department of Public Welfare, Bureau of Child Welfare, Division of Institutions ("DPW") was responsible for the management, supervision, and treatment of youth who were involved in the juvenile justice system.

18. From 1966 to 1969, the State Department of Juvenile Services ("SDJS") was responsible for the management, supervision, and treatment of youth who were involved in the juvenile justice system.

19. From 1969 to 1987, the Juvenile Services Agency within the Department of Health ("DH") (formerly the Department of Health and Mental Hygiene) was responsible for the management, supervision, and treatment of youth who were involved in the juvenile justice system.

20. In 1987, the Juvenile Services Agency ("JSA") was reorganized as an independent agency. JSA assumed responsibility from DH for the management, supervision, and treatment of youth who were involved in the juvenile justice system from 1987 to 1989.

21. In 1989, the State General Assembly established the modern-day Department of Juvenile Services ("DJS"). DJS assumed responsibility for the management, supervision and

treatment of youth who were involved in the juvenile justice system from 1989 to present. Between 1995 and 2003 DJS operated under the name "Department of Juvenile Justice."

## JURISDICTION AND VENUE

22. During the relevant period, the State of Maryland managed, supervised, and treated youth involved in the State's juvenile justice system through the agencies listed in paragraphs 17-21 above. Each of those agencies conducts or conducted business in Prince George's County, Maryland during the relevant period.

23. Venue in this Court is proper under Md. Code, Cts. & Jud. Proc. § 6-201, because Defendant "carries on a regular business" in Prince George's County.

24. Venue is also proper in this Court under Md. Code, Cts. & Jud. Proc. § 6-202(8) because Plaintiffs bring negligence claims "[w]here the cause of action arose." The events alleged occurred in Prince George's County.

25. Defendant is subject to the Maryland Tort Claims Act.

26. This action arises from claims of sexual abuse as defined in Md. Code, Cts. & Jud. Proc. § 5-117 and is exempt from the Maryland Tort Claims Act requirement to submit claims to the State Treasurer. Md. Code, State Gov't § 12-106(a)(2).

27. Plaintiffs' claims are not time-barred because they arise from incidents of sexual abuse that occurred while the victims were minors. Md. Code, Cts. & Jud. Proc. § 5-117(b).

28. The amount in controversy exceeds the jurisdictional minimum of $30,000.

## STATEMENT OF THE FACTS

### I. Background of Maryland's Juvenile Services and Cheltenham Juvenile Detention Facility

29. The Maryland Attorney General said, "Our judicial system should provide a means for victims who have suffered these harms to seek damages from the people and institutions responsible for them."[3]

[3] Gen. Anthony G. Brown, Attorney General's Report on Child Sexual Abuse in the Archdiocese of Baltimore 20 (Apr. 2023),

30. Several State Departments have been responsible for the management and operation of Maryland's juvenile detention facilities, including the Department of Education, the DPW, the SDJS, the DH, the JSA, and, since 1989, the DJS.[4]

31. In 1995, the Maryland General Assembly re-named the DJS the "Department of Juvenile Justice."[5] DJS operated under this name until 2003, when the General Assembly reverted DJS back to its original name.[6]

32. Within its broader mandate to manage, supervise, and treat youth who are involved in the juvenile justice system in Maryland, DJS is responsible for operation of Maryland's secure juvenile detention facilities.[7] At these facilities, Defendant purports to provide children educational, medical, counseling, and dietary services as well as recreational space.[8]

33. One of the juvenile detention facilities Defendant manages is Cheltenham Juvenile Detention Facility. In operation since 1870, Cheltenham was originally known as a "House of Reformation and Instruction for Colored Children."[9] In 1937, the facility was renamed the Cheltenham School for Boys. In 1949, it was again renamed the Boys' Village of Maryland. From 1992 to 2016, the facility was called the Cheltenham Youth Facility. Finally, since 2016, it has been known as the Cheltenham Youth Detention Center.[10]

34. Cheltenham is located in Prince George's County, at 11003 Frank Tippett Rd, Cheltenham, MD 20623.

35. DJS describes Cheltenham as a "secure detention facility for male and female youth

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https://www.marylandattorneygeneral.gov/news%20documents/OAG_redacted_Report_on_Child_Sexual_Abuse.pdf.

[4] History of Juvenile Justice in Maryland, Dep't of Juvenile Services, https://djs.maryland.gov/Pages/about-us/History.aspx (last visited Sep. 13, 2023).

[5] Historical Evolution Department of Juvenile Services, Maryland Manual On-Line, https://msa.maryland.gov/msa/mdmanual/19djj/html/djjh.html (last visited Sep. 14, 2023).

[6] *Id.*

[7] Detention and Community Supervision, Dep't of Juvenile Services, https://djs.maryland.gov/Pages/detention/Detention-Community-Supervision.aspx (last visited Sep. 13, 2023).

[8] Dep't of Juvenile Services, Cheltenham Youth Detention Center, https://djs.maryland.gov/Pages/facilities/Cheltenham-Youth-Detention-Center.aspx (last visited Sept. 25, 2023).

[9] J. Jones, *House of Reformation and Instruction for Colored Children*, Johns Hopkins, https://aspace.library.jhu.edu/repositories/3/archival_objects/240682 (last visited Sept. 25, 2023).

[10] Dep't of Juvenile Services, Cheltenham Youth Detention Center, https://djs.maryland.gov/Pages/facilities/Cheltenham-Youth-Detention-Center.aspx (last visited Sept. 25, 2023).

who are waiting to go to court or be placed in a treatment facility."[11] The facility is "a hardware secure (locked and fenced)" detention center.[12] It is located behind an alarmed, razor wire fence.[13]

36. Over its decades of operation, Cheltenham has housed children alleged to have committed a range of offenses, from truancy to murder. The facility has primarily served children from Prince George's, Montgomery, Anne Arundel, Calert, Charles, and St. Mary's Counties.[14]

37. As of 2004, the average stay for a child at Cheltenham was 25 days, with some children staying for more than 200 days.[15]

38. While the population of Cheltenham has fluctuated over the years, overcrowding has remained a consistent issue. At one time, Cheltenham simultaneously housed as many as 300 children.[16] The facility is currently approved to house 72 youths.[17]

## II. Defendant's Constitutional and Statutory Obligations

39. The 14th Amendment of the U.S. Constitution requires states to provide confined juveniles with reasonably safe conditions of confinement and must protect juveniles from physical assault and the use of excessive force by staff.[18] The Maryland Constitution provides similar protections to individuals in State custody.[19]

40. DJS is also statutorily obligated to establish regulations applicable to its residential facilities that "prohibit [the] abuse of a child," and to adopt regulations that require each State

[11] Dep't of Juvenile Services, Cheltenham Youth Detention Center, https://djs.maryland.gov/Pages/facilities/Cheltenham-Youth-Detention-Center.aspx (last visited Sept. 25, 2023).
[12] Juvenile Justice Monitoring Unit, Fourth Quarter Report and 2018 Annual Review (Apr. 2019), https://www.marylandattorneygeneral.gov/JJM%20Documents/JJMU_2018_Annual_Report.pdf.
[13] Juvenile Justice Monitoring Unit, Cheltenham Youth Facility Special Report (Oct. 2, 2008), https://www.marylandattorneygeneral.gov/JJM%20Documents/DJS_Response_102.pdf.
[14] Dep't of Juvenile Services, Cheltenham Youth Detention Center, https://djs.maryland.gov/Pages/facilities/Cheltenham-Youth-Detention-Center.aspx (last visited Sept. 25, 2023).
[15] U.S. Dep't of Just., Civil Rights Div., Investigation of the Cheltenham Youth Facility in Cheltenham, Maryland, and the Charles H. Hickey, Jr. School in Baltimore Maryland 3 (Apr. 9, 2004), https://www.justice.gov/sites/default/files/crt/legacy/2010/12/15/cheltenham_md.pdf.
[16] Todd Richissin, *Abuse of Teens Persists Despite State's Promises*, The Sun, Nov. 25, 2001, at A1, https://baltimoresun.newspapers.com/image/378208166/.
[17] Dep't of Juvenile Servs., Cheltenham Youth Detention Center, https://djs.maryland.gov/Documents/facilities/2021-DRG-Cheltenham.pdf (last visited Sept. 25, 2023).
[18] *See Youngberg v. Romeo*, 457 U.S. 307, 315-24 (1982).
[19] *See Williams v. Wilzack*, 573 A.2d 809, 814 (Md. 1990) (adopting Supreme Court precedent granting to persons in state custody, safe conditions of confinement on Fourteenth Amendment due process grounds).

residential program to provide "a safe, humane, and caring environment."[20]

41. DJS has additional non-discretionary statutory obligations related to the hiring and training of its employees. DJS must set "minimum . . . qualifications and standards of training and experience for the positions in the Department,"[21] and on or before the first day of employment with the Department must complete "a federal and State criminal history records check" for each employee.[22]

42. Finally, DJS has non-discretionary statutory obligations to "adopt a code of conduct for staff of the Department; and . . . require each private agency under contract with the Department to adopt a code of conduct for its staff that is in substantial compliance with the code of conduct for staff of the Department."[23]

43. DJS promulgated its own regulations, ostensibly to comply with its constitutional and statutory obligations. These regulations provide that acts of abuse are prohibited at DJS facilities, including both physical abuse and sexual abuse.[24]

44. DJS regulations also govern the Department's hiring and training practices:

a. "Each facility and other program shall maintain a staffing plan that, in accordance with Departmental requirements, provides a safe, humane, and caring environment."[25]

b. "All direct-care staff and all specialists shall: (1) Demonstrate the potential for working with youth in program settings, as reflected by academic qualifications, personal experience, or a combination of both; and (2) Meet the minimum qualifications, as applicable, set by: (a) The Department of Budget and Management; (b) The Maryland Correctional Training Commission; and (c) Applicable law and regulation."[26]

[20] Md. Code, Hum. Servs. § 9-237(b)(2).
[21] *Id.* § 9-208(1).
[22] *Id.* § 9-209(a)(1).
[23] *Id.* § 9-207(e).
[24] Md. Code Regs. § 16.18.02.01-02.
[25] Md. Code Regs. § 16.05.01.03(A).
[26] Md. Code Regs. § 16.05.02.01(B).

c. "All program staff shall be trained according to the standards set for the applicable position by the Maryland Correctional Training Commission."[27]

d. "The Secretary shall adopt and enforce a code of conduct for personnel of the Department,"[28] and "[e]very private vendor or other person providing services to the Department shall adopt and enforce, as a condition of its contract, grant, or other arrangement with the Department, a code of conduct that is substantially similar to the one adopted by the Secretary[.]"[29]

45. Defendant knew of the incidents and reports described below, and others, and was aware that Cheltenham and its other facilities failed to meet the minimum conditions required for its facilities by the U.S. and Maryland Constitutions and DJS's own authorizing statutes.

46. The failure to address and remediate the harms identified in the myriad internal and external investigations into the abuse and neglect of children at Cheltenham and other facilities directly enabled the sexual abuse of Plaintiffs.

## III. The Prevalence and Consequences of Sexual Assault in Juvenile Facilities

47. On September 4, 2003, President George W. Bush signed the Prison Rape Eliminate Act ("PREA") into law, following its passage by unanimous consent in both the U.S. House of Representatives and Senate. Incorporated into the law is a detailed list of Congressional findings.[30] Congress' relevant findings are quoted in full:

a. "[E]xperts have conservatively estimated that at least 13 percent of the inmates in the Unites States have been sexually assaulted in prison. Many inmates have suffered repeated assaults."[31]

b. "Young first-time offenders are at increased risk of sexual victimization."[32]

[27] Md. Code Regs. § 16.05.03.01.
[28] Md. Code Regs. § 16.05.04.01.
[29] Md. Code Regs. § 16.05.04.02.
[30] 42 U.S.C. § 15601.
[31] 42 U.S.C. § 15601(2).
[32] 42 U.S.C. § 15601(4).

c. "Most prison staff are not adequately trained or prepared to prevent, report, or treat inmate sexual assaults."[33]

d. "Prison rape often goes unreported, and inmate victims often receive inadequate treatment for the severe physical and psychological effects of sexual assault—if they receive treatment at all."[34]

e. "Victims of prison rape suffer severe physical and psychological effects that hinder their ability to integrate into the community and maintain stable employment upon their release from prison. They are thus more likely to become homeless and/or require government assistance."[35]

f. "[T]he high incidence of prison rape . . . increases mental health care expenditures, both inside and outside of prison systems, by substantially increasing the rate of post-traumatic stress disorder, depression, suicide, and the exacerbation of existing mental illnesses among current and former inmates[.]"[36]

## IV. A Pattern and Practice of Institutional Abuse Within the Maryland Juvenile Detention System and Cheltenham

48. Despite the well-established constitutional, statutory, and common law obligations to ensure the safety of children in its custody, Defendant's mismanagement of Cheltenham reveals a number of unaddressed structural deficiencies as well as a pattern and practice of the State shirking its responsibilities, and thus allowing the unchecked and criminal abuse and neglect of the children entrusted to its care.

49. This history is evidenced in a series of investigations and reports, by other government agencies, public interest groups, and the press.

50. In 1967, the United States Department of Health, Education and Welfare, predecessor to the Department of Health and Human Services, investigated Maryland's juvenile

[33] 42 U.S.C. § 15601(5).
[34] 42 U.S.C. § 15601(6).
[35] 42 U.S.C. § 15601(11).
[36] 42 U.S.C. § 15601(14)(D).

services system. It documented "an overuse of institutionalization," finding that the state's juvenile detention facilities were "too large" and recommending that the State "evaluate effective means of reducing the size of [its] institutions."[37]

51. In 1973, the Legal Defense and Educational Fund of the National Association for the Advancement of Colored People ("NAACP") reached similar conclusions in its report examining conditions at Maryland's juvenile detention facilities. The NAACP report concluded that the facilities "were largely custodial and not rehabilitative." It recommended that the current institutions "be phased out and replaced by a variety of community-based facilities."[38]

52. In 1986, a group of children detained at one of Maryland's now-defunct juvenile detention facilities (the Montrose School) sued the State, alleging that conditions at the Montrose School violated the civil and constitutional rights of its residents.[39] Among the abusive practices alleged in the lawsuit were the arbitrary and inappropriate use of isolation, an overuse of physical restraints and punishment—including a practice of staff members "body slamming" youth residents to control behavior—and a lack of staff oversight that enabled youth-on-youth sexual violence, rape, and multiple youth suicides.[40] The state of Maryland announced plans to close the Montrose School in September 1987, and the last child left the facility in March 1988.

### A. Early Evidence of Abuse at Cheltenham

53. The problems plaguing Maryland's juvenile detention facilities were fully present at Cheltenham. Reports dating back decades document deplorable conditions for children, a pattern of staff members physically, sexually, and psychologically abusing the children supposedly under their care, and a pervasive lack of oversight and regulation by Defendant.

54. For decades, staffers at Cheltenham have consistently abused the children in their

[37] Jeffrey A. Butts & Samuel M. Street, Youth Correction Reform: The Maryland and Florida Experience, 8 (1988) https://jeffreybutts.files.wordpress.com/1988/07/csyp-md.pdf (quoting U.S. Dep't of Health, Education and Welfare, A Study and Assessment of Maryland's Program and Facilities for the Treatment and Control of Juvenile Delinquency (1967)).
[38] *Id.* at 8-9 (quoting NAACP Legal Defense and Educational Fund, Inc., A Call for Reform of Maryland's Training Schools, A Report by the Task Force on Juvenile Justice (Feb. 1973)). Juvenile corrections facilities are sometimes referred to as "training schools." *Id.* at 2.
[39] *Id.* at 10.
[40] *Id.*

care, physically, sexually, and psychologically.

55. In 1943, Cheltenham's own Supervisor of Education admitted that the institution had a "restrictive prison-like atmosphere,"[41] and that "a year's stay in the unwholesome reform school atmosphere serves to intensify rather than ameliorate the boys' social maladjustment."[42]

56. In 1974, the Maryland State Police conducted a two-month investigation into the conditions at Cheltenham (then known as Boys Village).[43] The investigation concluded that "most problems [at Cheltenham] were caused by poor administration" by supervisors at the facility.[44] The investigators found that the administration at Cheltenham "was apparently handling their own problems and headquarters (the Department of Juvenile Services), by not hearing of their problems, assumed everything was all right and did not monitor the activities closely."[45] The investigators raised concerns about a "wall of protection that rose up around administration and staff resulting from their longevity in their positions which led to incomplete probes of allegations of brutality against staffers by juveniles."[46]

57. In February of 1989, a Cheltenham youth supervisor (akin to a guard[47]) was fired and criminally charged after helping four Cheltenham residents escape. Defendant learned only after the incident and arrest that the youth supervisor was a felon.[48] He had been hired and put in charge of caring for children at Cheltenham before the results of his background check were ever obtained.[49]

58. That same year, another counselor at Cheltenham was criminally charged with

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[41] Lisa Feldman, *et al.*, A Tale of Two Jurisdictions: Youth Crime and Detention Rates in Maryland & the District of Columbia 9 (Oct. 2001), https://static.prisonpolicy.org/scans/bby/dcmd.pdf.
[42] Vincent Schiraldi, *Time to Shut Down Cheltenham Once and For All*, The Sun, Mar. 31, 2003, at A17, https://baltimoresun.newspapers.com/image/248615188/.
[43] Norman Wilison, *Juvenile Institution Problem Laid to Poor Administration*, The Evening Sun, May 2, 1974, at E5, https://baltimoresun.newspapers.com/image/371820553/.
[44] *Id.*
[45] *Id.*
[46] *Id.*
[47] Upon information and belief, guards at Cheltenham have gone by a variety of titles, including but not limited to, officers, advocates, cottage parents, and youth supervisors.
[48] Liz Bowie, *Ex-Aide Charged with Helping 4 Flee Boys Village*, The Sun, Feb. 6, 1989, at D1, https://baltimoresun.newspapers.com/image/378009815/.
[49] *Id.*

sexually abusing a 12-year-old child at the facility. According to the charges, the counselor entered the child's room and forced the child to touch his penis.[50]

59. In 1991, a male nurse at Cheltenham was indicted on sexual abuse charges, after abusing 16 boys in just over a two-week period. According to the indictment, the nurse made sexual advances toward the boys and fondled them during their physical examinations.[51]

60. In 1995, Bart Lubow, a Senior Associate at Annie E. Casey Foundation in Baltimore, toured Cheltenham and described it as "a pretty horrific place." He recounted urine-soaked mattresses, peeling paint, and overpopulated cells.[52]

61. The same year, a report by the Youth Law Center noted "chronic overcrowding, gross inadequacy of basic services and programs, enormous difficulties in management and operations in the cottages, and insufficient numbers of staff for the population."[53]

62. In December 1995, *The Baltimore Sun* ("*The Sun*") also reported on the rampant overcrowding in Cheltenham, noting that "On an average day at this juvenile detention center in southern Prince George's, about 250 teenage boys—60 percent from Baltimore—spend as little as 1½ hours in school, sleep in tiny, bare cells built to hold a maximum of 167 boys, and wait."[54]

63. In June of 1999, reports revealed that a Cheltenham guard had impregnated a girl detained at Cheltenham.[55] In response, the agency demoted, but did not fire, Cheltenham's superintendent.[56] Defendant failed to publicly disclose either the pregnancy or the demotion until contacted by *The Sun*.[57] When the incident came to light, a spokesperson for the DJS stated that it

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[50] Lan Nguyen, *Sex-Abuse Case Forces CYBA to Review Hiring*, Howard County Sun, May 24, 1992, at 4, https://baltimoresun.newspapers.com/image/173724510/; Alan J. Craver, *Former Coach in Columbia Sentenced to Five Years for Molesting Two Boys*, The Sun, Feb. 24, 1993, at B4, https://baltimoresun.newspapers.com/image/170761892/.
[51] *Prince George's Nurse Indicted on Sex Charges*, The Sun, Aug. 22, 1991, at B3, https://baltimoresun.newspapers.com/image/375938591/.
[52] Lisa Feldman, *et al.*, A Tale of Two Jurisdictions: Youth Crime and Detention Rates in Maryland & the District of Columbia 9 (Oct. 2001), https://static.prisonpolicy.org/scans/bby/dcmd.pdf.
[53] *Id.*
[54] Kate Shatzkin, *Overcrowding at Juvenile Facility Targeted*, The Sun, Dec. 20, 1995, at B7, https://baltimoresun.newspapers.com/image/172871062/.
[55] Todd Richissin, *Head of Juvenile Jail Is Demoted*, The Sun, July 17, 1999, at B1, https://baltimoresun.newspapers.com/image/172822422/.
[56] *Id.*
[57] *Id.*

occurred because the administration at Cheltenham had failed to follow DJS policies.[58]

64. Later in 1999, a criminal investigation into three Maryland juvenile facilities found a pattern of abuse by guards.[59] This investigation was sparked not by reporting from staff or administrators at the facilities, nor by monitoring from Defendant, but by a series of articles from *The Sun* regarding guards at a Maryland juvenile boot camp routinely assaulting the youth residents—kicking, punching, and slamming them to the ground.[60] In the wake of this investigation, Maryland Governor Parris N. Glendening ordered monitoring of the State's juvenile detention centers.[61] This monitoring brought to light, for the first time, that Cheltenham had fired seven youth supervisors in just the past year for alleged abuse of residents.[62]

65. Despite this investigation and promises from the State of Maryland to reform the State's juvenile justice system, the problems of abuse persisted. In 2001, *The Sun* reported on the violence and abuse that remained rampant in Cheltenham and other Maryland juvenile detention centers. The report concluded that "[t]he roots of the violence" in Cheltenham and the other two largest Maryland juvenile detention centers, Victor Cullen Center and the Hickey School, had "been known for years: Guards at the facilities are poorly paid and receive little formal training."[63] *The Sun* through its investigation learned of 93 reports of staff members assaulting children in their care, and multiple instances of guards forcing children to participate in fight clubs with one another.[64] *The Sun* summarized the atrocities at Cheltenham and other such facilities succinctly: "[T]he violence at the facilities—along with more than 200 suicide-related incidents and a dozen reports of sexual assaults by guards against teens—exemplifies jails that may do more harm than good to juvenile offenders. Once released, nearly 80 percent commit another crime."[65]

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[58] *Id.*
[59] Kate Shatzkin, *Monitors Begin Their Watch at Youth Facilities*, The Sun, Dec. 15, 1999, at A1, https://baltimoresun.newspapers.com/image/173482911/.
[60] *Id.*
[61] *Id.*
[62] *Id.*; *see also* Todd Richissin, *Juvenile Justice Chief, Aides Ousted Over Camp Violence*, The Sun, Dec. 16, 1999, at A1, https://baltimoresun.newspapers.com/image/172266426/.
[63] Todd Richissin, *Abuse of Teens Persists Despite State's Promises*, The Sun, Nov. 25, 2001, at A1, https://baltimoresun.newspapers.com/image/378208166/.
[64] *Id.*
[65] *Id.*

66. At the time of this report, Cheltenham guards were paid just $10 per hour.[66] A 1995 advertisement for a "Youth Supervisor I" job opening at Cheltenham described the role as being "responsible for the care & supervision of youth in a detention facility."[67] The only listed requirement for the position was completion of high school or an equivalency certificate.[68] The salary was listed at just $8.41 per hour or $17,535 per year.[69] A similar 1999 advertisement for a "Youth Supervisor I" described the role as providing "supervision, crisis intervention, and counseling to detained youth."[70] The starting salary was listed as just $19,942 per year.[71] In addition to being underpaid, Cheltenham staff were overworked. Due to Cheltenham being "chronically understaffed," employees frequently worked 16-hour shifts.[72]

67. Local 3167 of the American Federation of State, County, and Municipal Employees was the union that represented Cheltenham guards. In 2001, the president of the union, Matt Riley, reported that he is "often disturbed by the treatment of juveniles at the facilities" and that "only when the state increases pay and improves training are the problems likely to subside."[73]

68. In April of 2002, a 44-year-old female guard at Cheltenham was charged with sexually assaulting a 14-year-old resident, in what the teen reported as a weeks-long "relationship."[74]

69. In December of 2002, guards herded children at Cheltenham out of their bunks in the middle of the night to watch at least two residents fight each other.[75]

70. In 2003, a boy at Cheltenham penned a letter describing his experience at the facility. He explained that staff punish children by locking them in their cells and getting other

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[66] *Id.*
[67] *Help Wanted*, The Sun, Jan. 29, 1995, at G22, https://baltimoresun.newspapers.com/image/373667676/.
[68] *Id.*
[69] *Id.*
[70] *General Help Wanted*, The Sun, July 25, 1999, at G30, https://baltimoresun.newspapers.com/image/173599244/.
[71] *Id.*
[72] Todd Richissin, *Abuse of Teens Persists Despite State's Promises*, The Sun, Nov. 25, 2001, at A1, https://baltimoresun.newspapers.com/image/378208166/.
[73] *Id.*
[74] *Cheltenham Guard Charged with Sexual Assault*, The Sun, Apr. 12, 2002, at B4, https://baltimoresun.newspapers.com/image/248482726/.
[75] Michael Dresser, *Staff's Conduct, Fight Among Youths Probed at Cheltenham*, The Sun, Dec. 17, 2002, at B8, https://baltimoresun.newspapers.com/image/264220165/.

kids to beat them up. The boy wrote that he was scared to come out of his closet-sized cell.[76]

71. In 2002, the Maryland legislature enacted a statute creating the Office of the Independent Juvenile Justice Monitor. In its annual report covering the period of July 2003 to July 2004, the Office reported to then-Governor Ehrlich on, among other things, the conditions at Cheltenham. The report documented that Cheltenham remained "understaffed and . . . in need of continued program enhancements." It found that "the pattern of under-reporting incidents persists in this facility."[77] The report also concluded that "DJS lacks quality-control procedures" across facilities," and that "a lack of training for both line and supervisory staff contributes to the problems within DJS facilities."[78]

72. In November of 2003, four Cheltenham staff members were fired for holding down a youth resident and hitting him repeatedly.[79] The incident was not publicly disclosed for over 2 months.[80]

73. In May of 2004, *The Sun* reported that 30 Cheltenham staffers were "quietly disciplined" for mistreating children in their care. Specifically, *The Sun* reported that children "as young as 11 allege[d] that they were punched or slapped by staff members, dragged by the hair and stabbed with a pen."[81] Afterwards, Cheltenham Superintendent Jimmy Lewis admitted, "We've still got some training to do."[82] He noted that the 134-year-old facility had "recently" begun offering guards an extra training session on the proper use of force.[83] According to *The Sun*, the "state has acknowledged difficulty hiring and retaining competent youth supervisors at Cheltenham."[84] This problem stemmed, in part, from the fact that Maryland paid supervisors

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[76] Vincent Schiraldi, *Time to Shut Down Cheltenham Once and For All*, The Sun, Mar. 31, 2003, at A17, https://baltimoresun.newspapers.com/image/248615188/.
[77] Juvenile Justice Monitor, Annual Report: July 1, 2003- June 30, 2004, https://msa.maryland.gov/megafile/msa/speccol/sc5300/sc5339/000113/003000/003124/unrestricted/20066498e.pdf (last visited Sept. 25, 2023).
[78] *Id.* at 18, 19.
[79] Jeff Barker, *30 Disciplined in Abuses at Cheltenham*, The Sun, May 21, 2004, at A1, https://baltimoresun.newspapers.com/image/248993960/.
[80] *Id.*
[81] *Id.*
[82] *Id.*
[83] *Id.*
[84] *Id.*

"significantly less than their counterparts in surrounding states."[85] Reports from the facility contained the following allegations:

a. A resident was allegedly placed in a chokehold by another resident for refusing to hand over snack food. Even as the boy was "gasping" for air, he maintained that the "staff on duty did not attempt to intervene." The victim also said a staff member was hitting residents with a stick.

b. A resident alleged that a female staff member "threatened him by telling him that she was going to have other youth '[beat] him up,' and that she could put a hit out on him."

c. A youth worker was observed in December by a fellow staff member "using excessive profanity and grabbing a youth by his hair."

d. A youth alleged in February that a staff member attacked him with a pen.[86]

**B. 2004 Department of Justice Investigation**

74. In 2004, the Department of Justice conducted a nearly two-years-long investigation of Cheltenham and Hickey School under the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 and the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141.

75. On April 9, 2004, the DOJ published the findings of the investigation in a 51-page report, finding "major constitutional deficiencies" in both facilities' failure to protect youth from staff violence, unsafe restraint practices, youth violence, excessive isolation, and physical and sexual assault by staffers.[87]

76. For instance, in April 2002, a Cheltenham staff member "resigned after it was revealed that she had engaged in sexual intercourse with a youth resident at Cheltenham."[88] The

[85] *Id.*
[86] *Id.*
[87] U.S. Dep't of Just., Civil Rights Div., Investigation of the Cheltenham Youth Facility in Cheltenham, Maryland, and the Charles H. Hickey, Jr. School in Baltimore, Maryland (April 9, 2004), https://www.justice.gov/sites/default/files/crt/legacy/2010/12/15/cheltenham_md.pdf.
[88] *Id.*

DOJ criticized Cheltenham for "fail[ing] to institute[] adequate measures to prevent incidents such as these [sexual abuses] from recurring" despite the fact that "[r]relationships of this variety clearly violate the Constitution."[89]

77. In addition to sexual abuse, the DOJ also found "pervasive violence" and a "deeply disturbing degree of physical abuse of youth by staff at . . . Cheltenham."[90]

78. For instance, in January 2004, Maryland State Police filed criminal assault charges against four Cheltenham staff members who restrained and assaulted a child. "The police investigation reveal[ed] that after the youth resisted going to bed early, four staff members grabbed him. The unit supervisor put the youth's arms in a chicken wing hold over his head while other staff members punched him in his face and kicked him in the ribs and back." After that beating, those staffers "dragged the youth back to his room and his pants and underwear had been ripped and pulled down to his ankles."[91]

79. On another occasion, after a restrained youth was placed in a transportation van, a staffer "entered the van and struck the youth with his fist."[92]

80. In February 2003, a child was upset after a staffer threw away his breakfast. The child "tried to push past the staff member to get out of his room," but the staffer "grabbed him by the throat and pushed him back onto the bed, chocking and cursing him." That child was then treated for injuries to his neck and throat.[93]

81. The DOJ also found that few cells at Cheltenham were equipped with toilets and sinks, leaving children to "urinate on their windowsills or into bed linens if they [were] not permitted to use the restroom." Investigators noted that "cells smelled strongly of urine" during their visits.[94]

82. These were not isolated abuses and failures. The DOJ explained that interviews

[89] *Id.* at 14.
[90] *Id.* at 4.
[91] *Id.* at 5.
[92] *Id.* at 6.
[93] *Id.*
[94] *Id.*

confirmed that "the above examples are representative of recurrent problems . . . and are not aberrational."[95]

83. Still, Cheltenham "failed to implement systemic measures to ensure that similar incidents [did] not occur."[96]

84. Relatedly, the DOJ determined: "The recurrent nature of the incidents reflects a lack of appropriate training, reporting, supervision, and quality assurance practices at Cheltenham."[97]

85. The DOJ documented specific and extreme failures in hiring and supervision. For instance, "individuals with felony convictions and histories of excessive force against juveniles may, at times, be hired as staff members at these facilities. Notably, we found several instances where we believe that staff with either felony convictions or previous histories of excessive force in a juvenile detention facility were involved in incidents of abuse. This is, quite obviously, entirely unacceptable."[98]

86. The DOJ found that "incident reporting by staff frequently fails to provide any detail regarding the incidents."[99]

87. The DOJ also concluded that the "pervasive violence at Cheltenham appears to result, in part, from the lack of sufficient numbers of adequately trained staff."[100]

88. The report noted that "youth-to-staff ratios at Cheltenham have been as high as 20:1 during the day and 60:1 at night," which "deviate substantially from generally accepted professional practices."[101]

89. Besides physical and sexual abuse by staff, the DOJ investigation identified several other ongoing and pervasive failures to protect youth at Cheltenham as well as the Hickey School: the use of unsafe restraint practices, failure to protect residents from youth-on-youth violence,

[95] *Id.*
[96] *Id.*
[97] *Id.*
[98] *Id.* at 6-7.
[99] *Id.*
[100] *Id.* at 9.
[101] *Id.*

excessive use of disciplinary isolation and lack of procedural protections in the use of disciplinary isolation, denial of access to bathrooms, failure to protect youth at risk of self-harm and suicide, inadequate mental health care, inadequate medical care, inadequate education instruction of youth with disabilities, and inadequate fire safety within both facilities.[102]

90. In June 2005, the DOJ announced a settlement agreement with the State of Maryland regarding Cheltenham, which would require the state to "implement reforms to ensure that juveniles in the facilities are protected from harm." The announcement of the settlement acknowledged that Cheltenham had a "long and troubled histor[y]," including "physical abuse of juveniles by staff."[103]

91. Disturbingly, as part of the settlement, the DOJ felt the need to include a provision that the State of Maryland "shall take all reasonable measures to assure that youth are protected from violence and other physical or sexual abuse by staff."[104] Also as part of the settlement, the State of Maryland agreed to implement a system whereby individuals entering the facility would receive "effective orientation that includes: simple directions for reporting abuse" and "assures youth of their right to be protected from harm and from retaliation for reporting allegations of abuse."[105] Upon information and belief, no such system was in place prior to the settlement.[106]

### C. Juvenile Justice Monitoring Unit Reports

92. The abuse uncovered by the DOJ continues today. The Juvenile Justice Monitoring Unit ("JJMU")—an independent State agency housed in the Office of the Maryland Attorney General—issues a yearly report about the juvenile detention facilities in Maryland. The JJMU has explained that children in Maryland's facilities—including Cheltenham—continue to suffer from the same pattern of abuse.

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[102] *Id.* at 5-47.
[103] Press Release, U.S. Dep't of Just., *Justice Department Settles Lawsuit Regarding Conditions of Confinement at Two Maryland Juvenile Justice Facilities* (June 30, 2005), https://www.justice.gov/archive/opa/pr/2005/June/05_crt_352.htm.
[104] U.S. Dep't of Just. & Maryland Settlement Agreement, https://clearinghouse-umich-production.s3.amazonaws.com/media/doc/19513.pdf (last visited Sept. 25, 2023).
[105] *Id.*
[106] Nor do Plaintiffs have information to confirm that such an "effective orientation" was ever implemented at the facility.

### *i. Conditions at Cheltenham and a Continued Pattern of Abuse from 2010 to 2015*

93. In 2010, the JJMU explained that Cheltenham was "the most overcrowded DJS-run facility in the State." Specifically, the two cottages that housed "older, bigger and more challenging youth" held "60% more youth than state DJS capacity allows," and both "have frequently been 100% over capacity." As a result, "two youths sleep in almost every cell – one in a metal frame bed and one on a plastic boat bed placed on a floor."[107] The JJMU also observed that cells were "decrepit and dirty," "strewn with trash," and covered in "years of built-up grime."[108] And furniture was "aged, broken, torn and potential dangerous."[109]

94. The JJMU also criticized Cheltenham for leaving children "locked in cells because of insufficient staff coverage."[110]

95. The JJMU found that staff at Cheltenham were "not reporting all aggressive incidents and seclusions of youth as required," which was "disturbing and cause for great concern."[111]

96. In 2011, JJMU found that Cheltenham "continue[d] to be plagued by overcrowded conditions."[112] As in 2010, "two boys [were] housed in almost every cell" and the facility "remain[ed] an inappropriate environment for youth residence."[113]

97. In 2011, staff used "physical restraints" on children as many as 555 times.[114]

98. In 2015, a child reported that "supervisory staff punched and choked him while conducting a strip search in the facility bathroom." And while administrators called Child Protective Services to report the abuse, "the supervisor was not removed from contact with children."[115]

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[107] Juvenile Justice Monitoring Unit, 2010 Annual Report 7 (Jan. 2011), https://www.marylandattorneygeneral.gov/JJM%20Documents/2010_annual_report%20.pdf.
[108] *Id.*
[109] *Id.* at 8.
[110] *Id.*
[111] *Id.* at 25.
[112] *Id.* at 26.
[113] *Id.*
[114] *Id.* at 10, 17.
[115] *Id.* at 28.

99. The same day, "the same supervisor was involved in a separate incident . . . during which he restrained a youth. However, he did not generate an incident report documenting the restraint as required by DJS policy."[116]

100. On another occasion in 2015, video captured a staffer who "slammed [a] child to the ground while trying to restrain him." Troublingly, in a review after the incident, Cheltenham "administrators failed to note that the staffer had inappropriately restrained the child and did not notify [Child Protective Services]. The OIG investigator called CPS to report the incident after reviewing the footage in the course of her investigation."[117]

101. The JJMU also noted the "need for enhanced staff training," particularly regarding mental health. For instance, during one monitoring visit, "[p]ersistent yelling by staffers escalated tensions on the unit and the youth bec[a]me increasingly frustrated."[118]

***ii. Conditions at Cheltenham and a Continued Pattern of Abuse from 2016 to 2023***

102. In 2016, the JJMU reported more troubling incidents. For instance, the report summarized the following event captured on surveillance:

> Video footage shows the unit manager restraining a youth in a chokehold for 25 seconds, while another youth strikes the unit manager in his lower body. The unit manager continues holding a youth in a chokehold and lifts one of the youth's feet off the ground and pulls him to the floor. The unit manager laid on top of the youth and the shift commander came over and "touched him several times to signal him to get up and release the pressure off of [the youth.]" The shift commander continued tapping the unit manager for 40 seconds before he got off the youth. Other youth reported that "it looked like [the youth] was about to be asleep."[119]

103. One child reflected on the incident: "[The unit manager] comes to work not to help us but to bully us because he [is] bigger and [has] authority."[120]

104. When Prince George's County Child Protective Services later tried to investigate the incident, "attempts by the [investigator] to request documents were delayed because no one at

[116] *Id.*
[117] *Id.*
[118] *Id.*
[119] *Id.* at 26 (alterations in original)
[120] *Id.* at 27.

[Cheltenham] answered or returned phone calls and messages."[121]

105. While that incident happened, another staffer was involved in a different altercation and had to be "held back by fellow staffers several times and he 'yank[ed] away from his peers in an aggressive manner' and moved in the direction of the youth's cell."[122]

106. The JJMU determined that the "uptick in incidents . . . suggests a need for increased training for direct-care staff to constructively manage group dynamics and implement conflict resolution techniques."[123]

107. In 2019, the JJMU emphasized the need for "training efforts that focus on de-escalation and utilizing a team approach, including assistance from colleagues, mental health staff, and supervisors, in addressing youth behavior rather than reliance on physical restraints and seclusion."[124]

108. Due do the lack of training, staffers often "resorted to inappropriate physical responses or displayed a lack of professional judgment out of frustration or impatience" with children at Cheltenham."[125]

109. For instance, after a staffer ordered a child to sit on a chair rather than a desk, the "staffer pushed the youth off the desk and the youth fell to the floor. The youth then got up from the floor and sat back down on the desk. The staffer pushed the youth again." And when a supervisor arrived to escort the child from the classroom, "the staffer pushed the youth again."[126]

110. In another incident, a staffer, who was frustrated that a youth was refusing to "lock in," "picked up a chair and threw it toward the mounted TV, striking it."[127]

111. On another occasion, a staffer argued "face to face" with a child "then physically restrained the youth and pulled him into his cell." The child later reported to medical staff with "a

[121] *Id.* at 27-28.
[122] *Id.* at 26.
[123] *Id.* at 24.
[124] Juvenile Justice Monitoring Unit, Fourth Quarter Report and 2019 Annual Review 20 (May 2020), https://www.marylandattorneygeneral.gov/JJM%20Documents/19_Annual_Report.pdf.
[125] *Id.*
[126] *Id.*
[127] *Id.*

bruise from the altercation."[128]

112. In 2021, a staffer observed two children arguing and did not try to de-escalate the argument. When the children began fighting, that staffer "stood watching the incident unfold."[129]

113. A staffer "ran out of the classroom" when children began fighting.[130]

114. A staffer falsely accused a child of stealing her watch—which had, in fact, been taken by another staffer for safekeeping—and grabbed and pushed the child. The staffer and child then began fighting each other and another child used the staffer's radio to call for help.[131]

115. A child "with serious mental health issues spit at a staffer and the staffer spat back at the youth." The child and staffer then began to fight.[132]

116. After one incident, several kids were locked in the movie room and one wrote in a grievance: "Staff left me in the movie room unattended and I was in there for hours and they had policemen with guns and tasers and batons [who] came [in] and I feared for my safety and a youth was maced and thrown in his cell with no medical attention [and] another youth couldn't breathe [and] I couldn't either."[133]

117. The JJMU concluded that Cheltenham was in "chronic need of experienced, active, and engaged leadership."[134]

118. In 2022, the JJMU found that Cheltenham "continued to expose kids to unsafe and dangerous conditions . . . and are guided by a corrections and compliance-oriented mindset rather than a child-centered approach."[135]

119. The JJMU explained that "[c]onditions (including very severe staffing shortages and youth confined to cells for long periods as a result) were especially acute at Cheltenham Youth

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[128] *Id.*
[129] Juvenile Justice Monitoring Unit, Fourth Quarter Report and 2021 Annual Review 11 (Mar. 2022), https://www.marylandattorneygeneral.gov/JJM%20Documents/2021_Annual_Report.pdf.
[130] *Id.*
[131] *Id.*
[132] *Id.*
[133] *Id.* at 16.
[134] *Id.* at 17.
[135] Juvenile Justice Monitoring Unit, 2022 Second Quarter Report (Sept. 2022), https://www.marylandattorneygeneral.gov/JJM%20Documents/22_Quarter2.pdf.

Detention Center."[136]

120. For instance, the JJMU found "youth were held in seclusion for over four hours following a group skirmish. Observation reports from direct-care staff and medical staff document that the youth were lying down, sitting calmly, and following directions for the majority of the time in seclusion. However, the shift commander continued to authorize seclusion for the youth even though DJS policy requires that youth be removed from seclusion when they no longer present an imminent threat of physical harm to themselves or others."[137]

121. On another occasion, "a youth was kept in seclusion for four hours. The shift commander documented that she visited the youth on seclusion at 5:45 pm and 6:45 pm and wrote that least restrictive measures were not possible as the reason for continued seclusion. The shift commander can be seen on video at 5:30 pm doing a brief visual check on the youth but there are no signs of processing with him about the incident. Despite documenting otherwise, there is no sign of the shift commander coming to check on the youth between 5:30 and 7:35 pm. The youth was finally released from seclusion by a staffer on the unit around 7:35 pm."[138]

122. The JJMU also described a case manager who was "in his office when he got up from his desk, walked out and into another room where a youth was sitting. The case manager yanked the youth's chair out from under him, causing the youth to fall to the ground. Shortly afterward, the case manager confronted the youth face to face and initiated an inappropriate and dangerous restraint by lifting the youth off the ground completely and carrying him to his room. Staff witness statements did not document the inappropriate restraint or the case manager's role in creating and escalating the incident. Supervisors continue to rely on this same case manager to assist with youth restraints."[139]

123. Staff also allow the children to fight each other. From 2019 to 2021, there were

[136] Juvenile Justice Monitoring Unit, Fourth Quarter Report and 2021 Annual Review 17 (Mar. 2022), https://www.marylandattorneygeneral.gov/JJM%20Documents/2021_Annual_Report.pdf.
[137] Juvenile Justice Monitoring Unit, 2022 Second Quarter Report (Sept. 2022), https://www.marylandattorneygeneral.gov/JJM%20Documents/22_Quarter2.pdf.
[138] *Id.* at 28.
[139] *Id.*

approximately 300 documented fights between children at the facility. And staff were often indifferent to those altercations, allowing them to happen.[140]

124. This year, the JJMU explained that the violence at Cheltenham is "compounded by a lack of adequate supervision and structure that contribute[s] to an overall unstable environment."[141]

125. Cheltenham also "lacked structured programming," which could have "helped in reducing the number of aggressive incidents."[142]

## V. Effects of Abuse at Cheltenham on Children

126. That sustained pattern of abuse takes its toll on every child at Cheltenham.

127. Today—just like in 1943—a stop at Cheltenham "serves to intensify rather than ameliorate [a child's] social maladjustment."[143]

128. Staffers know that Cheltenham harms and scars its residents. For instance, in 2022, Nick Moroney, Director of the JJMU, posted an article on LinkedIn about plans to close some of Maryland's juvenile detention facilities. In a comment, Angelia Blot, who was a resident advisor for Maryland Department of Juvenile Services from 2018-2019, wrote, "I worked at Cheltenham and that place is abusive to the young men there. Maryland Department of Juvenile Services needs a shake up. I hope when Sam Abed leaves things will be better. The blood bath fights that happen in Cheltenham [are] sick."[144]

129. The sexual abuse, the "blood bath" fights, the failure to train and monitor staff all take an extreme emotional toll on the children entrusted to the State's care at Cheltenham. From 2009 to 2023, there were approximately 470 documented instances of suicidal ideation, gesture, attempt, or behavior at the facility.[145]

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[140] *See generally* Juvenile Justice Monitoring Unit, 2019-2021 Reports.
[141] Juvenile Justice Monitoring Unit, 2023 First Quarter Report (June 2023), https://www.marylandattorneygeneral.gov/JJM%20Documents/23_Quarter1.pdf.
[142] *Id.* at 26.
[143] Vincent Schiraldi, *Time to Shut Down Cheltenham Once and For All*, The Sun, Mar. 31, 2003, at A17, https://baltimoresun.newspapers.com/image/248615188/.
[144] Angelia Blot, LinkedIn, https://www.linkedin.com/posts/nick-moroney-577499a_maryland-plans-to-close-multiple-juvenile-activity-6866767644746498050-X9BV/ (last visited Sept. 25, 2023).
[145] *See generally* Juvenile Justice Monitoring Unit, 2009-2023 Reports.

## VI. Abuse of Plaintiffs at Cheltenham

130. Plaintiffs are part of this story. They were sexually, physically, and verbally abused, and emotionally tortured. Staff turned a blind eye, allowing children to be molested, raped, assaulted, and abused. And those children still carry that trauma today. They are men and women now, but time has not faded their scars.

131. In each case, Defendant's staff/agent/employees (the Perpetrators described below) gained access to Plaintiffs by virtue of Plaintiffs' confinement in the facilities described below. The Perpetrators used their positions of trust, power, and authority over Plaintiffs to sexually abuse them.

**Plaintiff John Doe (CH) 1:**

132. Plaintiff John Doe (CH) 1 is a male and was a minor during the entire time of the sexual abuse alleged herein.

133. In or around 2006, John Doe (CH) 1 was placed in Defendant's custody, to be housed at Cheltenham. While at Cheltenham, at the age of approximately 15 or 16 years old, John Doe (CH) 1 was sexually abused by a female staff member/agent/employee.

134. The Cheltenham Perpetrator's abuse of John Doe (CH) 1 included, among other things:

a. Entering John Doe (CH) 1's cell at night or instructing John Doe (CH) 1 to wait for her in specified places, in order to sexually abuse him;
b. Forcing John Doe (CH) 1 to perform oral copulation on her;
c. Hitting or squeezing John Doe (CH) 1's face if the oral copulation he performed on her was not as she desired;
d. Making sexual comments to John Doe (CH) 1 while John Doe (CH) 1 performed oral copulation, such as "this is called being a good boy" or telling John Doe (CH) 1 she wanted to change his mind about being gay;
e. Grabbing and stimulating John Doe (CH) 1's genitals;
f. Inserting her finger into John Doe (CH) 1's anus.

135. The Cheltenham Perpetrator told John Doe (CH) 1 that she would get him killed if he ever told anyone about the sexual abuse.

136. After several of their encounters, the Cheltenham Perpetrator said, in sum and substance, "nothing ever happened, did it?"

137. The Cheltenham Perpetrator brought mouthwash to each encounter with John Doe (CH) 1 and at the end of each counter forced John Doe (CH) 1 to wash out his mouth with mouthwash multiple times.

138. The Cheltenham Perpetrator sexually abused John Doe (CH) 1, as described above, on a regular basis, more than thirty times during his stay at Cheltenham.

139. John Doe (CH) 1 was not aware of anyone at Cheltenham to whom he could report his repeated abuse.

140. In addition, in or around 2006, John Doe (CH) 1 was placed in Defendant's custody, to be housed at Baltimore City Juvenile Justice Center ("Baltimore City"). While at Baltimore City, at the age of approximately 15 or 16 years old, John Doe (CH) 1 was sexually abused by a female staff member/agent/employee. Upon information and belief, the Baltimore City Perpetrator held a supervisory role.

141. The Baltimore City Perpetrator's abuse of John Doe (CH) 1 included, among other things:

a. Bringing John Doe (CH) 1 into her office or the intake room, to get him alone;

b. Raping John Doe (CH) 1, by forcing him to penetrate her vaginally and engage in sexual intercourse;

142. The Baltimore City Perpetrator "rewarded" John Doe (CH) 1 for committing sex acts with her by letting him use her cellphone.

143. The Baltimore City Perpetrator threatened John Doe (CH) 1 that he could not have recreational time unless her performed sex acts with her.

144. Subsequent to John Doe (CH) 1's sexual abuse at the hands of the Cheltenham and Baltimore City Perpetrators, he began to experience multiple mental, emotional and

psychological problems, due to the sexual abuse, including, but not limited to: anxiety; depression; feelings of helplessness; lowered self-esteem; moodiness; difficulty in forming meaningful relationships with others; significant trust and control issues; difficulty sleeping; difficulty eating, difficulty leaving his home, flashbacks and intrusive thoughts; stress; nervousness; fear; embarrassment; shame; frequent suicidal thoughts; and loss of enjoyment of life.

145. John Doe (CH) 1 has been medicated for ongoing mental health issues and has sought therapy to cope with trauma caused by the sexual abuse described above.

146. Due to the trauma of his sexual abuse and his associated mental health issues, at times, John Doe (CH) 1 has had difficulty obtaining and maintaining employment.

**Plaintiff John Doe (CH) 2**

147. Plaintiff John Doe (CH) 2 is a male and was a minor during the entire time of the sexual abuse alleged herein.

148. In or around 1966, John Doe (CH) 2 was placed in Defendant's custody, to be housed at Cheltenham. While at Cheltenham, at the age of approximately 12 or 13 years old, John Doe (CH) 2 was sexually abused a male staff member/agent/employee.

149. The Perpetrator's abuse of John Doe (CH) 2 included, among other things:

a. Following John Doe (CH) 2 into the bathroom, when John Doe (CH) 2 left the recreational area to use the restroom.

b. Telling John Doe (CH) 2 to pull down his pants.

c. Raping John Doe (CH) 2 anally with his penis.

150. The above-described sexual abuse occurred on or around the first day that John Doe (CH) 2 arrived at Cheltenham.

151. John Doe (CH) 2 recalls the Perpetrator being the only guard in the cottage at the time of the sexual abuse.

152. Subsequent to John Doe (CH) 2's sexual abuse at the hands of the Perpetrator, he began to experience multiple mental, emotional and psychological problems, due to the sexual

abuse, including, but not limited to: anxiety; depression; feelings of helplessness; lowered self-esteem; sexual dysfunction; difficulty in forming meaningful relationships with others; significant trust and control issues; difficulty sleeping; flashbacks and intrusive thoughts; stress; nervousness; fear; embarrassment; shame; suicidal thoughts; and loss of enjoyment of life.

153. John Doe (CH) 2 began abusing alcohol to forget his sexual assault. John Doe (CH) 2 has struggled with alcohol abuse on and off in the decades since the sexual assault.

154. Due to the trauma of his sexual abuse and his associated mental health issues, at times, John Doe (CH) 2 has had difficulty obtaining and maintaining employment.

**Plaintiff John Doe (CH) 3**

155. Plaintiff John Doe (CH) 3 is a male and was a minor during the entire time of the sexual abuse alleged herein.

156. In or around 2001, John Doe (CH) 3 was placed in Defendant's custody, to be housed at Cheltenham. While at Cheltenham, at the age of approximately 13 years old, John Doe (CH) 3 was sexually abused by a male staff member/agent/employee.

157. The Perpetrator's abuse of John Doe (CH) 3 included, among other things:

a. Telling John Doe (CH) 3 to enter the storage room where the towels were stored, in order to get John Doe (CH) 3 alone;

b. Asking John Doe (CH) 3 "Do you want to be bad? You must have a big penis . . . let me see it, grab it";

c. Forcing John Doe (CH) 3 to show him his penis;

d. Forcing John Doe (CH) 3 to masturbate himself while the Perpetrator watched;

e. Forcing John Doe (CH) 3 to grab and stimulate the Perpetrator's penis until ejaculation;

f. Forcing John Doe (CH) 3 to masturbate himself while also grabbing and stimulating the Perpetrator's penis until ejaculation;

g. Hitting John Doe (CH) 3 in the chest for "being a tough guy."

158. The Perpetrator sexually abused John Doe (CH) 3, as described above, more than

five times.

159. The Perpetrator threatened John Doe (CH) 3 that he better not tell anyone. The Perpetrator was large and intimidating.

160. John Doe (CH) 3 is aware, through contemporaneous discussions with other residents at Cheltenham, that he was not the only resident who the Perpetrator was sexually abusing.

161. Subsequent to John Doe (CH) 3's sexual abuse at the hands of the Perpetrator, he began to experience multiple mental, emotional and psychological problems, due to the sexual abuse, including, but not limited to: anxiety; depression; lowered self-esteem; sexual dysfunction; difficulty in forming meaningful relationships with others; significant trust and control issues; embarrassment; shame; and loss of enjoyment of life.

162. Due to the trauma of his sexual abuse and his associated mental health issues, at times, John Doe (CH) 3 has had difficulty obtaining and maintaining employment.

**Plaintiff John Doe (CH) 4**

163. Plaintiff John Doe (CH) 4 is a male and was a minor during the entire time of the sexual abuse alleged herein.

164. In or around 2001, John Doe (CH) 4 was placed in Defendant's custody, to be housed at Cheltenham. While at Cheltenham, at the age of approximately 12 years old, John Doe (CH) 4 was sexually abused by a female staff member/agent/employee.

165. The Perpetrator's abuse of John Doe (CH) 4 included, among other things:

a. Making suggestive comments to John Doe (CH) 4 while she watched him shower;

b. Grabbing John Doe (CH) 4's genitals while he showered;

c. Forcing John Doe (CH) 4 to perform oral copulation on her;

d. Raping John Doe (CH) 4, by forcing him to penetrate her vaginally and engage in sexual intercourse;

e. Hitting John Doe (CH) 4 in the head.

166. The Perpetrator sexually abused John Doe (CH) 4, as described above,

approximately eleven times.

167. Aside from the incident in the shower, the Perpetrator would wait until John Doe (CH) 4 was alone in the laundry room for his work assignment to sexually abuse him.

168. John Doe (CH) 4 was aware that the Perpetrator was having sexual contact with other Cheltenham residents. John Doe (CH) 4 understood that if he was to report the Perpetrator's sexual abuse, the other residents she was engaging in sexual relationships with would harm him. On several occasions, one of those individuals came to John Doe (CH) 4 and started physical fights with him.

169. The Perpetrator would threaten John Doe (CH) 4 that if he did not engage with her sexually, she would tell other residents or the facility that he had harmed her in some way.

170. Ultimately, John Doe (CH) 4 did report the Perpetrator's abuse to two other staff members at Cheltenham. The first staff member believed John Doe (CH) 4 and took his report seriously. That staff member went with John Doe (CH) 4 to report the abuse to the unit manager.

171. The unit manager did not believe John Doe (CH) 4's report that he was being sexually abused. Instead, the unit manager placed John Doe (CH) 4 on lockdown for two weeks, meaning that he was confined to his cell, only being let out for showers. John Doe (CH) 4 was then moved to another unit and placed in what was known as the isolation room for a week and a half, under the false pretense that he wanted to harm himself.

172. Within a month or two of John Doe (CH) 4 reporting the abuse, the first staff member, who took John Doe (CH) 4's report of abuse seriously, was fired.

173. Subsequent to John Doe (CH) 4's sexual abuse at the hands of the Perpetrator, he began to experience multiple mental, emotional and psychological problems, due to the sexual abuse, including, but not limited to: anxiety; depression; difficulty in forming meaningful relationships with others; significant trust and control issues; difficulty sleeping; flashbacks and intrusive thoughts; shame; and loss of enjoyment of life.

174. Due to the trauma of his sexual abuse and his associated mental health issues, at times, John Doe (CH) 4 has had difficulty obtaining and maintaining employment.

**Plaintiff John Doe (CH) 5**

175. Plaintiff John Doe (CH) 5 is a transgender female and was a minor during the entire time of the sexual abuse alleged herein. John Doe (CH) 5 presented as a male during the time period of the sexual abuse alleged herein.

176. In or around 1999, John Doe (CH) 5 was placed in Defendant's custody, to be housed at Cheltenham. While at Cheltenham, at the age of approximately 11 or 12 years old, John Doe (CH) 5 was sexually abused by a staff member/agent/employee.

177. The Perpetrator's abuse of John Doe (CH) 5 included, among other things:

a. Separating John Doe (CH) 5 from the general population of Cheltenham residents;

b. Purporting to separate John Doe (CH) 5 from the general population to protect John Doe (CH) 5's safety because John Doe (CH) 5 was much smaller than most Cheltenham residents;

c. Bringing John Doe (CH) 5 along with him on tasks around the facility, in an effort to get John Doe (CH) 5 alone;

d. Once alone, forcing John Doe (CH) 5 to grab and stimulate the Perpetrator's genitals until ejaculation;

e. Rubbing John Doe (CH) 5's chest and squeezing John Doe (CH) 5's nipples under John Doe (CH) 5's shirt;

f. Inserting his fingers into John Doe (CH) 5's anus.

178. The Perpetrator sexually abused John Doe (CH) 5, as described above, approximately eleven times.

179. John Doe (CH) 5, and other residents who John Doe (CH) 5 observed, endured constant physical and verbal abuse from the guards at Cheltenham. John Doe (CH) 5 was hit, smacked, thrown to the ground, and knocked in the head by guards. John Doe (CH) 5 was verbally assaulted on a regular basis. John Doe (CH) 5 did not feel there was anyone to report the sexual, physical, and verbal abuse to. John Doe (CH) 5 does not recall ever being told how to

report abuse that was occurring in Cheltenham.

180. John Doe (CH) 5 observed there to be a culture of abuse at Cheltenham that was sometimes discussed among the residents.

181. Subsequent to John Doe (CH) 5's sexual abuse at the hands of the Perpetrator, John Doe (CH) 5 began to experience multiple mental, emotional and psychological problems, due to the sexual abuse, including, but not limited to: anxiety; depression; moodiness; difficulty in forming meaningful relationships with others; significant trust and control issues; difficulty sleeping; flashbacks and intrusive thoughts; stress; nervousness; fear; suicidal thoughts; and loss of enjoyment of life.

182. Due to the trauma of John Doe (CH) 5's sexual abuse and John Doe (CH) 5's associated mental health issues, John Doe (CH) 5 has had difficulty obtaining and maintaining employment.

**Plaintiff John Doe (CH) 6**

183. Plaintiff John Doe (CH) 6 is a male and was a minor during the entire time of the sexual abuse alleged herein.

184. In or around 2000, John Doe (CH) 6 was placed in Defendant's custody, to be housed at Cheltenham. While at Cheltenham, at the age of approximately 15 years old, John Doe (CH) 6 was sexually abused by a male staff member/agent/employee. Upon information and belief, the Perpetrator held a supervisory role among the guards.

185. The Perpetrator's abuse of John Doe (CH) 6 included, among other things:

a. Threatening John Doe (CH) 6 that if he did not perform oral copulation on him, the Perpetrator would beat him up every night until he agreed to;

b. Physically assaulting John Doe (CH) 6 when he initially refused to perform oral copulation;

c. Forcing John Doe (CH) 6 to perform oral copulation on him;

d. Performing oral copulation on John Doe (CH) 6, while other residents held John Doe (CH) 6 down;

186. The Perpetrator sexually abused John Doe (CH) 6, as described above, approximately 15-20 times.

187. Subsequent to John Doe (CH) 6's sexual abuse at the hands of the Perpetrator, he began to experience multiple mental, emotional and psychological problems, due to the sexual abuse, including, but not limited to: anxiety; difficulty in forming meaningful relationships with others; significant trust and control issues; difficulty sleeping; flashbacks and intrusive thoughts; stress; nervousness; fear; and loss of enjoyment of life.

**Plaintiff John Doe (CH) 7**

188. Plaintiff John Doe (CH) 7 is a male and was a minor during the entire time of the sexual abuse alleged herein.

189. In or around 1999, John Doe (CH) 7 was placed in Defendant's custody, to be housed at Cheltenham. While at Cheltenham, at the age of approximately 16 years old, John Doe (CH) 7 was sexually abused by a female staff member/agent/employee.

190. The Perpetrator's abuse of John Doe (CH) 7 included, among other things:

a. Rubbing John Doe (CH) 7's genitals;

b. Forcing John Doe (CH) 7 to make oral and hand contact with her breasts;

c. Performing oral copulation on John Doe (CH) 7;

d. Forcing John Doe (CH) 7 to perform oral copulation on her.

191. The Perpetrator sexually abused John Doe (CH) 7, as described above, at least fifteen times.

192. Subsequent to John Doe (CH) 7's sexual abuse at the hands of the Perpetrator, he began to experience multiple mental, emotional and psychological problems, due to the sexual abuse, including, but not limited to: anxiety; depression; lowered self-esteem; shame; embarrassment difficulty in forming meaningful relationships with others; significant trust and control issues; flashbacks and intrusive thoughts; nervousness; fear; and loss of enjoyment of life.

193. John Doe (CH) 7 has been medicated for ongoing mental health issues and has

sought therapy to cope with trauma caused by the sexual abuse described above.

194. Due to the trauma of his sexual abuse and his associated mental health issues, at times, John Doe (CH) 7 has had difficulty obtaining and maintaining employment.

**Plaintiff John Doe (CH) 8**

195. Plaintiff John Doe (CH) 8 is a male and was a minor during the entire time of the sexual abuse alleged herein.

196. In or around 1996, John Doe (CH) 8 was placed in Defendant's custody, to be housed at Cheltenham. While at Cheltenham, at the age of approximately 13 or 14 years old, John Doe (CH) 8 was sexually abused by a male staff member/agent/employee.

197. The Perpetrator's abuse of John Doe (CH) 8 included, among other things:

a. Removing John Doe (CH) 8 from his cell at nighttime and bringing him to the Perpetrator's office;

b. Forcing John Doe (CH) 8 to remove his clothes or stripping John Doe (CH) 8's clothes off;

c. Raping John Doe (CH) 8 anally.

198. The Perpetrator threatened to physically harm John Doe (CH) 8 if he ever told anyone about the sexual abuse. The Perpetrator told John Doe (CH) 8 he would break his jaw or ribs.

199. The Perpetrator sexually abused John Doe (CH) 8, as described above, approximately five to ten times.

200. Subsequent to John Doe (CH) 8's sexual abuse at the hands of the Perpetrator, he began to experience multiple mental, emotional and psychological problems, due to the sexual abuse, including, but not limited to: anxiety; depression; feeling isolated and alone; feeling anti-social, difficulty in forming meaningful relationships with others; significant trust and control issues; flashbacks and intrusive thoughts; stress; nervousness; embarrassment; shame; suicidal thoughts; and loss of enjoyment of life.

201. Due to the trauma of his sexual abuse and his associated mental health issues, at times, John Doe (CH) 8 has had difficulty obtaining and maintaining employment.

**Plaintiff Jane Doe (CH) 1**

202. Plaintiff Jane Doe (CH) 1 is a female and was a minor during the entire time of the sexual abuse alleged herein.

203. In or around 1991, Jane Doe (CH) 1 was placed in Defendant's custody, to be housed at Cheltenham. While at Cheltenham, at the age of approximately 13 years old, Jane Doe (CH) 1 was sexually abused by a male staff member/agent/employee.

204. The Perpetrator's abuse of Jane Doe (CH) 1 included, among other things:

a. Entering Jane Doe (CH) 1's cell, shared with other minor females, forcing his hand into Jane Doe (CH) 1's shirt and groping her breasts;

b. Entering Jane Doe (CH) 1's cell, shared with other minor females, grabbing Jane Doe (CH) 1's hand and forcing Jane Doe (CH) 1 to grope his penis;

c. Following Jane Doe (CH) 1 into the shower and penetrating her vagina with his fingers.

205. Jane Doe (CH) 1 is aware that other girls at Cheltenham also suffered sexual abuse by the staff members. It was Jane Doe (CH) 1's impression that those supervising the staff members at Cheltenham knew this abuse was occurring but "no one cared." After Jane Doe (CH) 1 told other employees at Cheltenham about the abuse, she was moved out of a group room and put in "lockdown," before being transferred out of Cheltenham to a group home.

206. Subsequent to Jane Doe (CH) 1's sexual abuse at the hands of the Perpetrator, she began to experience multiple mental, emotional, and psychological problems, due to the sexual abuse, including, but not limited to: manic depression, long-term substance abuse, suicidal ideation, a suicide attempt, feelings of helplessness; intense anger issues; inability to form healthy relationships with males; significant difficulties interacting with family and friends; flashbacks and intrusive thoughts, stress; fear; embarrassment; shame; and loss of enjoyment of life.

207. Due to the trauma of his sexual abuse and his associated mental health issues, at times, Jane Doe (CH) 1 has had difficulty obtaining and maintaining employment.

**Plaintiff Jane Doe (CH) 2**

208. Plaintiff Jane Doe (CH) 2 is a female and was a minor during the entire time of the sexual abuse alleged herein.

209. In or around 1990, Jane Doe (CH) 2 was placed in Defendant's custody, to be housed at Cheltenham. While at Cheltenham, at the age of approximately 15 years old, Jane Doe (CH) 2 was sexually abused by a male staff member/agent/employee.

210. The Perpetrator's abuse of Jane Doe (CH) 2 included, among other things:

a. Entering her cell at night, where she slept alone;

b. Walking in on her while she was changing clothes;

c. Making lewd, inappropriate, and deeming sexual comments;

d. Groping her vaginal area and breasts;

e. Penetrating her vagina with his fingers;

f. Raping her vaginally, sometimes while physically holding her down;

g. Striking her in the mouth.

211. The Perpetrator told Jane Doe (CH) 2 that he knew her family's addresses and phone numbers and would kill them if she told anyone. The Perpetrator also threatened to kill her and suggested that people would think it was a suicide.

212. The Perpetrator sexually abused Jane Doe (CH) 2, as described above, on a regular basis during the one to one and a half years that Jane Doe (CH) 2 was at Cheltenham.

213. On numerous occasions, Jane Doe (CH) 2 reported her abuse to individuals at Cheltenham, but, to the best of her knowledge, nothing ever came of her reporting.

214. Subsequent to Jane Doe (CH) 2's sexual abuse at the hands of the Perpetrator, she began to experience multiple mental, emotional and psychological problems, due to the sexual abuse, including, but not limited to: anxiety; depression; lowered self-esteem; moodiness; difficulty in forming meaningful relationships with others; significant trust and control issues;

flashbacks; stress; nervousness; fear; embarrassment; shame; suicidal thoughts; and loss of enjoyment of life.

215. Jane Doe (CH) 2 has been medicated for ongoing mental health issues and has sought therapy to cope with trauma caused by the sexual abuse described above.

216. Due to the trauma of her sexual abuse and her associated mental health issues, at times, Jane Doe (CH) 2 has had difficulty obtaining and maintaining employment.

## JOINT AND SEVERAL LIABILITY

217. Plaintiffs plead joint and several liability pursuant to Md. Code, Cts. & Jud. Proc. § 3-1403 such that the Defendant and any future parties joined to this action are liable for the full amount of any judgment or verdict entered herein.

## RESPONDEAT SUPERIOR

218. As principal and/or employer of perpetrators and other offending parties described herein, Defendant is liable for their wrongful acts and omissions under the doctrine of *respondeat superior* and other vicarious liability principles found in the Second Restatement of Agency. Defendant maintained at all times a non-delegable duty to youth in the care and custody of facilities it was charged with managing, overseeing, and operating.

## IMMUNITIES

219. While Maryland has waived immunity under the Maryland Child Victims Act and Md. Code, St. Gov't § 12-104, to the extent claims herein trigger any governmental immunities, damages are sought only under and up to the amount of insurance coverage available.

220. Each event complained of by each Plaintiff herein caused a distinct injury and is pled as a separate incident or occurrence.

## CAUSES OF ACTION

### COUNT I: NEGLIGENCE

221. The preceding paragraphs are incorporated by reference as if set forth in their entirety herein.

222. At various relevant times, Defendant was required to appropriately manage,

supervise, and treat youth involved in the juvenile justice system in Maryland.[146] It was responsible for all aspects of care, protection and services for youth in their custody, including but not limited to housing, provisions, education, nurture, care and personal safety, and protection.

223. Given this level of control over residents' lives, Defendant stood *in loco parentis* and owed Plaintiffs a heightened duty of care akin to special care or a fiduciary level of care.

224. These duties and obligations are statutorily mandated and are non-delegable. Even though Defendant has, through the years, contracted with third party providers as agents for some of these services, the ultimate responsibility for oversight, management, and operations at all levels of Cheltenham remains with Defendant, as assigned by the Legislature.

225. These duties and obligations require Defendant to meet applicable standards of care for facilities such as Cheltenham under its operation and control.

226. These duties and obligations extended to all youth residents, and specifically to Plaintiffs.

227. Defendant breached each of these and other duties in one or more of the following ways:

a. Failing to properly manage and staff facilities;
b. Failing to supervise youth to ensure they were protected from sexual abuse, both by staff and by fellow youth, while at each facility;
c. Failing to provide an environment that was free from sexual abuse;
d. Failing to investigate and respond to youth complaints of sexual abuse;
e. Failing to provide medical treatment, therapy and/or counseling for youth who were sexually abused in a facility;
f. Failing to rectify and eliminate sexual abuse, including but not limited to terminating perpetrators and those who knew and contributed to tolerance of the

[146] *See* About Us, Maryland Dep't of Juv. Srvs., https://djs.maryland.gov/Pages/about-us/About.aspx (last visited Sept. 27, 2023).

abuse;

g. Such other failures as may become apparent through further investigation and discovery.

228. Defendant directly breached these duties required by statute and/or applicable standards of care.

229. As a direct and proximate result of these breaches, or any one or more of them, Plaintiffs were each harmed and suffered losses as follows:

a. Physical injuries and disfigurement, past and continuing into the future;

b. Severe emotional distress, past and continuing into the future;

c. Expenses relating to medical care and treatment, past and continuing into the future;

d. Lost wages and lost opportunities, past and continuing into the future;

e. Other economic losses, past and continuing into the future;

f. Loss of enjoyment of life, past and continuing into the future;

g. Litigation costs and expenses;

h. Prejudgment and post judgment interests at the legally proscribed rates;

i. Plaintiffs seek an award of attorney's fees as permissible by Md. Rule 2-702 and 2-703(b) and other applicable authorities; and

j. Such other relief as the Court may deem appropriate or as may be uncovered through further investigation and discovery.

**COUNT II: GROSS NEGLIGENCE**

230. The preceding paragraphs are incorporated by reference as if set forth in their entirety herein.

231. Defendant maintained at all times a manifest duty to hire safe and qualified individuals, to supervise them properly, and to terminate any employee or staff who posed a danger to or sexually abused a youth.

232. Defendant intentionally failed to act on decades of complaints and allegations

both from youth residents and independent evaluators which informed Defendant that numerous staff had, and were continuing to, perpetrate sexual abuse upon the youth in their care.

233. These failures were in reckless disregard of the grave consequences to youth, including Plaintiffs, which damaged them in body, mind, and their abilities to thrive and enjoy normal lives, as set forth with particularity above.

234. As such, Defendant was grossly negligent in failing to perform its statutorily mandated, nondelegable and assumed duties to protect Plaintiffs and other youth from sexual abuse.

235. As a result of this gross negligence, the sexual abuse at Cheltenham was tolerated, and proliferated among more and more staff as years went on.

236. As a direct and proximate result of these breaches, or any one or more of them, Plaintiffs were each harmed and suffered losses as follows:

a. Physical injuries and disfigurement, past and continuing into the future;
b. Severe emotional distress, past and continuing into the future;
c. Expenses relating to medical care and treatment, past and continuing into the future;
d. Lost wages and lost opportunities, past and continuing into the future;
e. Other economic losses, past and continuing into the future;
f. Loss of enjoyment of life, past and continuing into the future;
g. Litigation costs and expenses;
h. Punitive damages;
i. Prejudgment and post judgment interests at the legally proscribed rates;
j. Plaintiffs seek an award of attorney's fees as permissible by Md. Rule 2-702 and 2-703(b) and other applicable authorities; and
k. Such other relief as the Court may deem appropriate or as may be uncovered through further investigation and discovery.

**COUNT III: NEGLIGENT SUPERVISION, HIRING, AND RETENTION**

237. The preceding paragraphs are incorporated by reference as if set forth in their entirety herein.

238. Defendant had statutory, mandated, non-delegable duties in regard to hiring staff at all levels within its management and operation of juvenile justice facilities, including Cheltenham.

239. Defendant directly hired individuals at executive levels to oversee, manage and operate juvenile justice facilities including Cheltenham.

240. In addition, Defendant selected and hired both direct employees and third party agents and providers to oversee, manage, and operate Cheltenham.

241. Defendant paid those employees, agents and/or providers to undertake these tasks, directly or indirectly, such that DJS stood in the place of a principal and employer as to each of them.

242. Defendant had a non-delegable duty to ensure that only qualified and competent staff were hired at all levels to serve and protect the residents at Cheltenham and other facilities under its control.

243. Defendant breached this duty and others by failing to establish appropriate, minimal requirements for executives, providers and staff.

244. Defendant breached this duty and others by hiring unqualified and incompetent executives, providers and staff.

245. Defendant had actual or constructive knowledge of these individuals' incompetence and/or dangerous propensities.

246. Defendant would have known of these individuals' proclivities if they had undertaken an appropriate background search in connection with hiring them or vetting them prior to granting them access to youth (including Plaintiffs) in their care.

247. Defendant had a further non-delegable duty to monitor and supervise staff at all levels within its operation of Cheltenham and other facilities under its control to ensure that services and protections were afforded to youth in its care, including Plaintiffs.

248. Defendant breached this duty by failing to monitor and supervise their staff to ensure that sexual abuse was not occurring.

249. Defendant breached this duty by failing to investigate complaints both by youth residents and by independent evaluators that staff and youth at Cheltenham and other facilities under their control were perpetrating sexual abuse upon residents, including Plaintiffs.

250. Defendant had a duty to retain only safe and qualified staff to serve youth in their care, and to terminate any staff who sexually abused a youth.

251. Defendant breached this duty by continuously retaining staff members whom they knew or should have known had dangerous propensities and/or had sexually abused youth.

252. Each of these breaches violated Defendant's statutorily mandated duties and applicable standards of care.

253. Defendant had the power to terminate its employees who failed to protect youth from sexual abuse.

254. Defendant failed to exercise this power and was negligent in both the supervision and retention of its employees.

255. Had Defendant acted appropriately and not failed in any one or more of the above duties of hiring, supervising, and/or retaining proper staff, the harm to Plaintiffs would have been prevented and they would not have been injured.

256. The acts and omissions of Defendant's employees, staff, and/or agents, as well as those of its selected third-party providers, are imputable to Defendant.

257. As a direct and proximate result of these breaches, or any one or more of them, Plaintiffs were each harmed and suffered losses as follows:

a. Physical injuries and disfigurement, past and continuing into the future;

b. Severe emotional distress, past and continuing into the future;

c. Expenses relating to medical care and treatment, past and continuing into the future;

d. Lost wages and lost opportunities, past and continuing into the future;

e. Other economic losses, past and continuing into the future;

f. Loss of enjoyment of life, past and continuing into the future;

g. Litigation costs and expenses;

h. Prejudgment and post judgment interests at the legally proscribed rates;

i. Plaintiffs seek an award of attorney's fees as permissible by Md. Rule 2-702 and 2-703(b) and other applicable authorities; and

j. Such other relief as the Court may deem appropriate or as may be uncovered through further investigation and discovery.

**COUNT IV: NEGLIGENT FAILURE TO TRAIN AND EDUCATE**

258. The preceding paragraphs are incorporated by reference as if set forth in their entirety herein.

259. Defendant, as custodian *in loco parentis* of Plaintiffs, owed a special duty of care and/or was in a fiduciary relationship with Plaintiffs, who were vulnerable, otherwise unaccompanied minors in its residential facilities.

260. Defendant, through the above captioned agencies, also had a special duty of care to ensure Plaintiffs' safety and well-being due to the agencies' non-delegable and non-discretionary duties as the state agencies charged with overseeing Maryland's juvenile detention centers.

261. Among those duties, Defendant had a duty to take reasonable measures to protect the Plaintiffs and other children from sexual abuse.

262. Defendant also had a duty to properly train and educate its staff/employees/agents at all levels to protect Plaintiffs and to prevent them from being sexually abused.

263. Defendant or others acting on its behalf or under its direction or control, breached these duties to Plaintiffs by, among other things:

a. Failing to protect Plaintiffs from sexual abuse while in its facilities;

b. Failing to properly train or educate staff/employees/agents (direct and third parties) on behaviors constituting sexual abuse by staff and/or among residents;

c. Failing to properly train or educate staff/employees/agents (direct and third parties) on how to uncover and recognize sexual abuse;

d. Failing to properly train or educate staff/employees/agents (direct and third parties) on how to monitor the facilities to prevent sexual abuse;

e. Failing to properly train or educate staff/employees/agents (direct and third parties) on how to establish and maintain proper channels whereby residents could report abuse;

f. Failing to properly train or educate staff/employees/agents (direct and third parties) on how to investigate allegations of sexual abuse;

g. Failing to properly train or educate staff/employees/agents (direct and third parties) on how to respond to, document and report allegations of sexual abuse; and

h. In such other ways as may become apparent through further investigation and discovery.

264. Defendant knew or should have known, and it was foreseeable in these circumstances, that it had created an opportunity for vulnerable children (including Plaintiffs) to be sexually abused.

265. As a direct and proximate result of these breaches, or any one or more of them, Plaintiffs were each harmed and suffered losses as follows:

a. Physical injuries and disfigurement, past and continuing into the future;

b. Severe emotional distress, past and continuing into the future;

c. Expenses relating to medical care and treatment, past and continuing into the future;

d. Lost wages and lost opportunities, past and continuing into the future;

e. Other economic losses, past and continuing into the future;

f. Loss of enjoyment of life, past and continuing into the future;

g. Litigation costs and expenses;

h. Prejudgment and post judgment interests at the legally proscribed rates;

i. Plaintiffs seek an award of attorney's fees as permissible by Md. Rule 2-702 and 2-703(b) and other applicable authorities; and

j. Such other relief as the Court may deem appropriate or as may be uncovered through further investigation and discovery.

**COUNT V: PREMISE LIABILITY**

266. The preceding paragraphs are incorporated by reference as if set forth in their entirety herein.

267. Plaintiffs were tenants or invitees of Defendant while within its residential custody and on its premises.

268. As such, Defendant owed Plaintiffs a duty of reasonable care under all circumstances in the management, oversight, and operation of its facilities/premises. This included a duty to employ reasonable measures to protect Plaintiffs against foreseeable dangers such as sexual abuse by staff and/or other residents.

269. Defendant knew or should have known of the risk that staff/employees/agents might sexually abuse tenants/invitees such as Plaintiffs, and therefore had a duty to take reasonable measures to eliminate the conditions contributing to sexual abuse.

270. Defendant had a specific and non-delegable duty to provide reasonable security measures to eliminate conditions contributing to foreseeable harm such as sexual abuse.

271. Defendant had prior knowledge of sexual abuse occurring on the premises of its various facilities, as evidenced by past events cited above. This created a duty to eliminate the risk that sexual abuse would recur.

272. In the alternative, Defendant had a duty to prevent sexual abuse by specific persons whom it knew or should have known had sexual predatory tendencies; those being staff/agents/employees and/or residents who perpetrated upon Plaintiffs.

273. In the alternative, Defendant had a duty to prevent sexual abuse of residents based on its knowledge of like events occurring within its various facilities prior to the actual sexual

abuse of Plaintiffs, all of which made imminent harm foreseeable.

274. Defendant breached its duties and created a foreseeable risk of harm by, among other things:

a. Failing to properly protect Plaintiffs, then minors, from sexual abuse;

b. Failing to properly vet third party providers (entities) to ensure they and their staff did not present a risk of sexually abusing Plaintiffs and other minor residents entrusted in their care;

c. Failing to properly vet its own direct staff/employees/agents and those of third party providers to ensure they did not present a risk of sexually abusing Plaintiffs and other minor residents entrusted in their care;

d. Failing to investigate, correct, and/or otherwise rectify the openly pervasive environment of sexual abuse of its residents;

e. Ignoring and/or otherwise failing to properly address complaints about numerous instances of sexual abuse occurring in and among its facilities;

f. Failing to promptly report Plaintiffs' sexual assaults to the authorities, which would have triggered a law enforcement response and prevention of further sexual abuse;

g. Failing to take any action to prevent retaliation against residents who reported sexual abuse, which in turn led to under-reporting and further proliferation of the abuse;

h. Failing to conduct an exit interview with residents when they left Defendant facilities, which would have identified sexual abusers and prevented further abuse;

i. Failing to supervise, monitor, and/or train staff to handle reports of sexual abuse appropriately and adequately; and,

j. In such other ways as may become apparent through further investigation and discovery.

275. Defendant knew or should have known that its acts and omissions created an opportunity and unreasonable risk for Plaintiffs to be sexually abused.

276. As a direct and proximate result of these breaches, or any one or more of them, Plaintiffs were each harmed and suffered losses as follows:

a. Physical injuries and disfigurement, past and continuing into the future;

b. Severe emotional distress, past and continuing into the future;

c. Expenses relating to medical care and treatment, past and continuing into the future;

d. Lost wages and lost opportunities, past and continuing into the future;

e. Other economic losses, past and continuing into the future;

f. Loss of enjoyment of life, past and continuing into the future;

g. Litigation costs and expenses;

h. Prejudgment and post judgment interests at the legally proscribed rates;

i. Plaintiffs seek an award of attorney's fees as permissible by Md. Rule 2-702 and 2-703(b) and other applicable authorities; and

j. Such other relief as the Court may deem appropriate or as may be uncovered through further investigation and discovery.

**COUNT VI: ARTICLE 24 MARYLAND DECLARATION OF RIGHTS – SUBSTANTIVE DUE PROCESS**

277. The preceding paragraphs are incorporated as though fully set forth herein.

278. The Perpetrators acted under color of the laws of the State of Maryland.

279. Plaintiffs have a substantive due process right to bodily autonomy under Article 24 of the Maryland Declaration of Rights.

280. The Maryland Constitution and principles of *respondeat superior* require Defendant to avoid Constitutional violations by its employees through adequate training and supervision and by disciplining employees for unlawful conduct. The Perpetrators of repeated acts of sexual abuse against Plaintiffs acted under color of the laws of the State of Maryland in their

role as employees, staff, or agents responsible for the management and operation of Cheltenham.

281. All the Perpetrators' actions occurred within the course of their duty and within the scope of their employment at Cheltenham.

282. The Perpetrators repeatedly violated Plaintiffs' rights under Article 24.

283. Defendant is vicariously liable for the Perpetrators' violations of Plaintiffs' rights under Article 24.

284. Thus, Defendant deprived Plaintiffs of their right to bodily autonomy under Article 24 when the Perpetrators repeatedly sexually abused Plaintiffs.

285. As a direct and proximate cause of the Defendants' unconstitutional conduct, Plaintiffs were deprived of their substantive due process rights to bodily autonomy.

286. As a direct and proximate result of Defendants' unconstitutional conduct, or any one or more of them, Plaintiffs were each harmed and suffered losses as follows:

a. Physical injuries and disfigurement, past and continuing into the future;
b. Severe emotional distress, past and continuing into the future;
c. Expenses relating to medical care and treatment, past and continuing into the future;
d. Lost wages and lost opportunities, past and continuing into the future;
e. Other economic losses, past and continuing into the future;
f. Loss of enjoyment of life, past and continuing into the future;
g. Litigation costs and expenses;
h. Prejudgment and post judgment interests at the legally proscribed rates;
i. Plaintiffs seek an award of attorney's fees as permissible by Md. R. Civ. Pro. Cir. Ct. 2-702 and 2-703(b) and other applicable authorities; and
j. Such other relief as the Court may deem appropriate or as may be uncovered through further investigation and discovery.

## COUNT VII: ARTICLE 24 MARYLAND DECLARATION OF RIGHTS – PATTERN AND PRACTICE (*LONGTIN* CLAIM)

287. The preceding paragraphs are incorporated as though fully set forth herein.

288. It is the custom and practice of Defendant to permit staffers to violate children's substantive due process rights to bodily integrity by physically and sexually abusing them.

289. Defendant failed to properly train and supervise their staffers to prevent those repeated Constitutional violations.

290. That failure to supervise demonstrates gross disregard for and deliberate indifference to Plaintiffs' Constitutional rights.

291. The failure to train Cheltenham staffers is so patently obvious from the repeated sexual abuse that Plaintiffs and other children at Cheltenham have experienced for decades.

292. As a result of the failure to train and the permitted pattern of practice at Cheltenham, staffers are allowed to sexually assault children.

293. Cheltenham staff fail to report these incidents of reckless and intentional unlawful conduct, and Defendant lacks effective procedures to control or monitor Cheltenham staffers who have a pattern or history of unlawful behavior.

294. Defendant caused Cheltenham staffers to believe that unlawful sexual abuse would not be aggressively, honestly, and properly investigated.

295. Defendant should have foreseen that such a policy would promote illegal and unconstitutional behavior.

296. This custom and practice directly and proximately caused Plaintiffs' Constitutional injury.

297. As a direct and proximate result of Defendant's unconstitutional pattern and practice, Plaintiffs were each harmed and suffered losses as follows:

a. Physical injuries and disfigurement, past and continuing into the future;

b. Severe emotional distress, past and continuing into the future;

c. Expenses relating to medical care and treatment, past and continuing into the

future;

d. Lost wages and lost opportunities, past and continuing into the future;

e. Other economic losses, past and continuing into the future;

f. Loss of enjoyment of life, past and continuing into the future;

g. Litigation costs and expenses;

h. Prejudgment and post judgment interests at the legally proscribed rates;

i. Plaintiffs seek an award of attorney's fees as permissible by Md. Rule 2-702 and 2-703(b) and other applicable authorities; and

j. Such other relief as the Court may deem appropriate or as may be uncovered through further investigation and discovery.

**PRAYER FOR RELIEF**

298. WHEREFORE, Plaintiffs hereby demands judgment against the Defendant in an amount in excess of the Court's jurisdictional minimum, compensatory damages, punitive damages where allowed by law, general damages in an amount to be determined by a jury, and pre- and post-judgment interest, together with the court costs necessitated in and about the prosecution of this action, including attorneys' fees and expenses, and all such further and additional relief as this Honorable Court deems just, fair and appropriate under the circumstances.

**PLAINTIFFS DEMAND A TRIAL BY JURY PURSUANT TO MD. R. CIV. P. CIR. CT. 2-325**

This the 1st day of October, 2023.

Respectfully submitted,

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