IN THE CIRCUIT COURT FOR BALTIMORE COUNTY, MARYLAND

JOHN DOES (BCJJC) 1-6,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	
The STATE OF MARYLAND, acting through its agencies, MARYLAND DEPARTMENT OF JUVENILE SERVICES, and/or DEPARTMENT OF HEALTH (formerly the DEPARTMENT OF HEALTH AND MENTAL HYGIENE),	)	**Civil Case No.:**
	)	
	)	**COMPLAINT**
	)	
	)	**Filed:**
	)	
	)	
	)	
Defendant.	)	

"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."

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

I. INTRODUCTION

The Department of Juvenile Services ("DJS" or the "Department") is "a child-serving agency responsible for assessing the individual needs of referred youth and providing intake, detention, probation, commitment, and after-care services," with a vision of creating "Successful Youth, Strong Leaders, [and] Safer Communities." The Department provides a laundry list of goals, including to "[i]mprove positive outcomes for justice-involved youth," to "only use incarceration when necessary for public safety," to "keep committed and detained youth safe while delivering services to meet youth needs," and to "build, value, and retain a diverse, competent, and professional workforce and to enhance the quality, availability, and use of technology to improve services for staff, youth, and families."

In the name of rehabilitation and reform, the DJS is statutorily authorized to operate centers such as the Baltimore City Juvenile Justice Center ("BCJJC") where the state may send boys who are in the stages of pre-adjudication and those who are already committed to the care of the DJS. Through the BCJJC, and other facilities like it, the State of Maryland accepts full control of every aspect of the children's lives, including housing, rehabilitation, feeding, supervision, education, nurture, and, most importantly, personal protection. The DJS claims that the rehabilitation that it provides to the children within its facility walls is crucial to reform them into productive and fulfilled adult citizens, but in actuality, it locks them inside a cage to become the prey of sadistic staff whom they cannot escape. Despite the cursory and superficial goals that the DJS claim to be their core tenants, the children that are involuntarily committed to facilities such as the BCJJC often leave far more damaged than when they entered.

The BCJJC opened on October 30, 2003. Since its doors opened, the facility has been plagued with overpopulation, severe understaffing, overuse of custodial punishments such as confinement and isolation, unacceptably high rates of physical and sexual abuse from staff and youths alike, and worse. The BCJJC's mission is not to incarcerate youths, but to rehabilitate them. The facility is only successful in the first part of their mission, as life in the facility is far worse than incarceration, so much so that conditions within the facility have created a mental health crisis for the juveniles committed there. Countless failed suicide attempts are overshadowed by the boys who succeeded. Terrifying stories of rape and violence leads the children to fear for their lives. Any attempts at reporting the conditions of the facility are quickly dissuaded by bribery, and if unsuccessful, threats and violence.

During the time that each Plaintiff was in the direct custody, care, control, and direction of the State of Maryland's Department of Juvenile Services at the BCJJC, its employees, agents, and

contractors exploited their positions of trust and authority to abuse Plaintiffs in horrific ways. Furthermore, these agents, employees, and contractors abandoned any duty they owed to Plaintiffs in protecting them from themselves, other youths, and adults at the facility. Plaintiffs were harassed; groped; forced to masturbate in front of perpetrators; forced to perform oral sex on perpetrators; anally penetrated with fingers and objects; and anally raped. The abuse occurred throughout the facility as a whole. Victims who sought to come forward were coerced into silence through isolation, physical restraints, abuse, or worse. Plaintiffs, and other former residents in a similar situation, were wholly unable to seek help or redress for the injuries they sustained at the BCJJC as their pleas for help were outright ignored until only recently.

This action seeks redress for the horrors and harms exacted on Plaintiffs and others who endured similar abuse for years while they resided at the BCJJC; to recover damages for the abundant and lasting scars, both physical and mental, that Plaintiffs will be forced to carry for the rest of their lives; to punish the perpetrators; and to ensure that this abuse or any like it is never allowed again under the watch of the State of Maryland.

II. PARTIES

A. Plaintiffs

1. All prior paragraphs are restated herein by this reference.

2. Plaintiffs John Does (BCJJC) 1-6 are men who, as children, were placed by the State of Maryland at the BCJJC in Baltimore County, Maryland. Plaintiffs are now adult residents and citizens of various states.

3. Plaintiffs John Does (BCJJC) 1-6 file this Complaint anonymously under the pseudonyms of John Doe pursuant to agreement and stipulation of Maryland's Attorney General.

4. Plaintiffs are all persons who as minors were detained or incarcerated within Maryland's juvenile justice system at the times of the acts complained of herein. Md. Code, Courts

and Judicial Proceedings § 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.

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

6. 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.

7. Additionally, the 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.

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

9. 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.

B. Defendant

10. All prior paragraphs are restated herein by this reference.

11. Defendant, the State of Maryland ("the State" or "Defendant") enforces Maryland's laws through its Executive Branch, consisting of various officers and agencies as authorized by

Maryland's Constitution and its laws. 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.

12. From 1969 to 1987, the Juvenile Service Agency within the Department of Health and Mental Hygiene ("DHMH") was responsible for the management, supervision, and treatment of youth who were involved in the juvenile justice system. DHMH was renamed to the Department of Health in 2017.

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

14. In 1989, the State General Assembly established the 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."

III. JURISDICTION AND VENUE

15. All prior paragraphs are restated herein by this reference.

16. 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 12 - 14 above. Each of those agencies conducts or conducted business in Baltimore County, Maryland during the relevant period.

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

18. 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 Baltimore County.

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

20. 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 Government § 12-106(a)(2).

21. 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. Article § 5-117(b).

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

IV. FACTUAL ALLEGATIONS

A. Structure and Background of the Maryland Juvenile Justice Detention System and the Baltimore City Juvenile Justice Center.

23. All prior paragraphs are restated herein by this reference.

24. The current Maryland Juvenile Justice Detention System was established nearly two centuries ago with the Maryland State Legislature's passing of "An Act to Establish a House of Refuge for Juvenile Delinquents" ("the Act") in 1830.[1]

25. The first house of refuge created by the Act was located in Baltimore City and began operations in 1855.[2] Since then, dozens of similar facilities have been opened under the Act.

26. Since the inception of the Juvenile Justice Detention System, a variety of different state departments have been responsible for the management and operation of these facilities. First

[1] 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).
[2] *Id*.

was the Department of Education, then the Department of Public Works, then the Juvenile Services Administration within the DHMH, and finally, since 1989, the DJS.[3]

27. In 1995, the Maryland General Assembly re-named DJS the "Department of Juvenile Justice."[4] DJS operated under this name until 2003, when the General Assembly reverted DJS back to its original name.[5]

28. Within its broader mandate to manage, supervise, and treat youth who are involved in the juvenile justice system in Maryland, DJS is responsible for the operation of Maryland's secure juvenile detention facilities.[6]

29. DJS is currently the administrative agency of the State charged with setting standards for juvenile detention facilities that are operated both by DJS as well as private agencies.[7]

30. The standards reflect adherence to three critically important central purposes of juvenile detention: 1) to protect the public; 2) to provide a safe, humane, and caring environment for children; and 3) to provide access to required services for children.[8]

31. DJS has a statutory mandate to establish regulations that "prohibit [the] abuse of a child" in its residential facilities and require each DJS residential program to provide "a safe, humane, and caring environment."[9]

32. Despite its statutory obligations, enacted regulations, and policies, DJS has failed to prevent the systematic physical and sexual abuse of children within its facilities for decades.

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[3] *Id.*
[4] 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).
[5] *Id*.
[6] Detention and Community Supervision, Dep't of Juvenile Services, https://djs.maryland.gov/Pages/detention/Detention-Community-Supervision.aspx (last visited Sep. 13, 2023).
[7] Md. Code Ann., Hum. Servs. § 9-237.
[8] *Id*., at (b)(1)-(3).
[9] HS § 9-227.

33. The 14th Amendment of the U.S. Constitution requires states to provide confined juveniles with reasonably safe conditions of confinement and to protect juveniles from physical assault and the use of excessive force by staff.[10] The Maryland Constitution provides similar protections to individuals in State custody.[11]

34. 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 residential program to provide "a safe, humane, and caring environment."

35. 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,"[12] 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.[13]

36. DJS also 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."[14]

37. DJS promulgated its own regulations, ostensibly to comply with its constitutional and statutory obligations which provide that acts of abuse are prohibited at DJS facilities, including both physical abuse and sexual abuse.[15]

38. DJS regulations also govern the Departments hiring and training practices:

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[10] *See Youngberg v. Romeo*, 457 U.S. 307, 315-24 (1982).
[11] *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).
[12] Md. Code, Hum. Servs § 9-208(1).
[13] Md. Code, Hum. Servs § 9-209(a)(1).
[14] Md. Code, Hum. Servs § 9-207(e).
[15] Md. Code Regs § 16.18.02.01-02.

a. "Each facility and other program shall maintain a staffing plan that, in accordance with Departmental requirements, provides a safe, humane, and caring environment."[16]

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."[17]

c. "All program staff shall be trained according to the standards set for the applicable position by the Maryland Correctional Training Commission."[18]

d. "The Secretary shall adopt and enforce a code of conduct for personnel of the Department,"[19] 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[.]"[20]

39. There are two ways a juvenile may enter the juvenile justice system, either by police arrest or a citizen complaint.

40. This means that once a child is arrested or detained due to a citizen complaint, they are unable to leave the facility until the day their commitment ends.

41. Consistent with its statutory obligations, DJS has implemented regulations for state-operated residential facilities that ostensibly prohibit acts of abuse within state facilities, including the "physical injury of a youth by any employee under circumstances that indicate the youth's health or welfare is significantly harmed or at risk of being significantly harmed," and the "sexual abuse of a youth, whether or not physical injuries are sustained."[21]

42. The DJS acts as principal, employer, overseer, manager, and operator of the BCJJC.

[16] Md. Code Regs § 16.05.01.03(A).
[17] Md. Code Regs § 16.05.02.01(B).
[18] Md. Code Regs § 16.05.03.01.
[19] Md. Code Regs § 16.05.04.01.
[20] Md. Code Regs § 16.05.04.02.
[21] Md. Code Regs § 16.18.02.01-02.

43. The BCJJC, opened in 2003, was created to provide children involved in the juvenile justice system an opportunity to become productive and fulfilled adult citizens.

44. The BCJJC facility is a multi-purpose juvenile justice building, housing court rooms, hearing rooms, offices for attorneys and law enforcement, social services departments, and the detention center that holds its juvenile male offenders, largely from Baltimore City.

45. The BCJJC, while operated by the DJS, works closely with the clerk of courts, also located within the BCJJC facility, to provide clerical support to judges at the BCJJC.

46. The DJS controls the charging and prosecution of juvenile criminal cases within the BCJJC, including the booking process arraignments, adjudications, detention reviews, court order reviews, hearings, dispositions, restitution hearings, violation-of-probation hearings, permanency plan reviews, and more.

47. The BCJJC detention center serves both as a pre-adjudication facility as well as a facility for youths who have already been adjudicated and committed to the care of the DJS.

48. When a youth is either arrested by police or detained due to a citizen complaint, they are sent into the BCJJC and do not leave the four walls of the facility until the entirety of the adjudication and incarceration is complete.

49. In a perfect world where the facility remained consistent with its statutory obligations, this system operated by the DJS would raise no issue and would in fact be a cost and space effective solution for the juvenile justice system. However, in reality, the DJS has consistently failed to prevent the systemic physical and sexual abuse of the children within its care for decades.

50. The DJS knew of the incidents and reports described herein, and others, and was aware that the BCJJC failed to meet the minimum conditions required for its facilities by the U.S. and Maryland Constitutions and its own authorizing statutes.

51. The failure to address and remediate the harms identified in the myriad internal and external investigations, as discussed herein, into the abuse and neglect of children at the BCJJC directly enabled the sexual abuse of Plaintiffs.

52. As a result, the juveniles that are sent to BCJJC, even before their adjudication, are trapped in a cesspit of rampant sexual and physical abuse by sadistic youth and staff.

B. **The Institutional Abuse Rampant Within the Juvenile Justice System and the BCJJC**

53. All prior paragraphs are restated herein by this reference.

54. The rampant physical and sexual abuse within the BCJJC as well as the juvenile justice system as a whole was well known by faculty staff and juvenile residents, as well as the public due to frequent reviews by state departments, publicized incidents of abuse, and testimonials by former inmates.

55. In 1967, the U.S. Department of Health, Education and Welfare, the predecessor agency to the U.S. Department of Health and Human Services, conducted a review of Maryland's juvenile services system.[22]

56. The U.S. Department of Health and Human Services' report described Maryland's juvenile detention facilities as, "too large," and recommended that the state "evaluate effective means of reducing the size of [its] institutions."[23]

[22] 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)).
[23] *Id.*

57. In 1973, the National Association for the Advancement of Colored People (NAACP) reached similar conclusions in its report examining the conditions at Maryland's juvenile detention facilities.

58. The NAACP recommended that Maryland's Training Schools, including the Montrose School, "be phased out and replaced by a variety of community-based facilities."[24]

59. In 1986, youth residents detained at the Montrose School, a now-closed Maryland juvenile detention facility, filed a class-action lawsuit against the state alleging that conditions within the school violated the civil and constitutional rights of its residents.[25] 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.[26]

60. This led to the closure of the Montrose School in 1988, but only alleviated a single symptom of the disease that plagues the overarching juvenile justice system as a whole.

61. State Department reviews of the Maryland Juvenile Justice system have found that the Maryland juvenile detention facilities have the highest rates of sexual abuse nationwide. This alarmingly high rate of abuse indicates that detention facilities across the state have failed to protect youth inmates from sexual abuse, and that they may be liable for the damages suffered by survivors with potential claims.[27]

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[24] *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)).
[25] *Id.* at 10.
[26] *Id*.
[27] *Id*. (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)).

62. In 2006, the Civil Rights Division of the Maryland Attorney General's Office ("the CRD") investigated the conditions and practices within the BCJJC pursuant to 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. The Civil Rights Department had the authority to investigate the facility and seek remedies for any pattern or practice of conduct that violates the constitutional or federal statutory rights of children in juvenile justice institutions.

63. The CRD concluded that a number of conditions and practices at the BCJJC violated the constitutional and federal statutory rights of its youth residents.[28] The BCJJC facility was described as a "dangerous and often chaotic" prison-like environment where the administration has failed to maintain stability and the youth are exposed to rampant abuse of physical, mental, and sexual natures.[29]

64. Specifically, the CRD found that the children confined to the BCJJC suffer significant harm and risk of harm from the facility's failures to (i) adequately protect children from youth violence, (ii) adequately safeguard youths against suicide, and (iii) adequately provide behavioral health care services.[30]

65. In its report, the CRD stated that "the [BCJJC] experiences unacceptably high levels of youth-on-youth violence" with a rate of youth-on-youth violence being a staggeringly 47% higher than the national average.[31]

[28] Letter from The Civil Rights Division of The Office of the Maryland State Attorney General to Honorable Robert L. Ehrlich, Jr., 2006, *Investigation of the Baltimore City Juvenile Justice Center in Baltimore, Maryland*, Baltimore, Maryland.
[29] *Id*.
[30] *Id*.
[31] *Id*.(According to Performance Based Standards data for the October 2005 semi-annual reporting cycle, the Justice Center reported a rate of assaults per 100 days of youth confinement at 0.745.2 The national field average rate was 0.396.)

66. The CRD found that the violence against its youth inhabitants, both by staff and youth, was both brazen and premeditated.[32]

67. The report states that the system was so ineffective that the aggressors "feel comfortable in orchestrating such activity."[33]

68. At the time of the CRD's review of the BCJJC, the BCJJC facility was plagued with chronic and severe understaffing, which contributed to the violent and dangerous conditions within the facility.

69. Understaffing has been an issue within the Maryland Juvenile Justice System for decades, if not centuries. Reports have found that staff at these facilities, such as the BCJJC, work four to five double shifts within a single week, just to ensure that the facility is meeting its staffing ratios.

70. The CRD also reported inadequate and inconsistent monitoring of juveniles and documentation thereof.[34]

71. Youths in seclusion are in significant danger of self-harm as well as sexual and physical assault by facility staff.[35] As a result, generally accepted professional standards and DJS policy require that direct-care staff monitor residents in seclusion every ten minutes and record their rounds on a door sheet or other log. The CRD report found that there was severely insufficient documentation to confirm that the checks at the BCJJC were performed in accordance with DJS policy or within the generally accepted professional standards whatsoever.[36]

[32] *See Id.*
[33] *Id.*
[34] *Id.*
[35] *See Id.*
[36] *Id.*

72. The CRD found a multitude of discrepancies between the DJS policy and the BCJJC's actions, to wit:

a. Youths in isolation at the BCJJC were in seclusion for hours at a time without any checks from staff;

b. There was a significant amount of missing documentation regarding after hour cell-checks by staff;

c. There were many discrepancies between the unit logbook entries and the door sheets; and

d. There were apparent gaps in seclusion monitoring and suicide watch monitoring for high risk and known suicidal youths.

73. In sum, the staff at the BCJJC were fully enabled to have free roam of the facility due to an utter lack of oversight by BCJJC management, DJS, and Defendant alike.

74. As a direct result of the dangerous levels of understaffing these facilities, such as the BCJJC, experience, sexual and physical abuse against the youth therein is not only enabled, but has become rampant.

75. In the conclusion of the CRD report, the office of the State Attorney General threatened litigation, stating that if "we are unable to reach a resolution regarding our concerns, the Attorney General is empowered to institute a lawsuit pursuant to CRIPA to correct the deficiencies of the kind identified in this letter."[37]

76. The CRD report was not new or groundbreaking information, as the public has been aware of the egregious abuse plaguing juvenile detention centers and calling for the closure of these facilities for decades.[38]

77. The public outcry against juvenile detention centers is not the result of state investigations into these facilities. Rather, the outcry is often the catalyst.

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[37] *Id.*

[38] Butts, *Youth Correction Reform: The Maryland and Florida Experience*, (1988).

78. The rampant abuse experienced within these facilities is frequently publicized, and largely shared via testimony by former residents and detainees.

79. Former residents who were victims under the care of these institutions, if they were not dissuaded from doing so by bullying tactics, bribery, or threats, have previously gone to news and media outlets, or, more recently, have gone to social media to search for other victims with similar stories.[39]

80. Former residents of Maryland juvenile institutions have gone to popular social media sites like YouTube to share their story and have found hundreds of comments detailing stories of similar abuse, either experienced or witnessed by former students, residents, and detainees.[40]

81. Before social media outlets were so widely used, gruesome stories of abuse were shared in newspaper articles or other similar media outlets.[41]

82. Each facility currently and previously operated by the DJS has their own distinct and horrendous publicized first-person accounts. The BCJJC, a relatively newer facility, is frequently featured in newspaper and magazine articles detailing the violence that occurs there, to wit:

a. June 2005: As officers were escorting youths back from recreation, two youths began arguing. Staff directed the youths to separate, but one youth ultimately struck the other youth. During the ensuing melee, the victim fell back splitting the back of his head open;[42]

[39] *See* Picturethis43, *Montrose School Alumni?*, YouTube (Oct. 9, 2007) https://www.youtube.com/watch?v=t0duSEwA0PE.
[40] *Id*.
[41] *See* Butts, *Youth Correction Reform: The Maryland and Florida Experience*, (1988).
[42] Letter from The Civil Rights Division of The Office of the Maryland State Attorney General to Honorable Robert L. Ehrlich, Jr., 2006, *Investigation of the Baltimore City Juvenile Justice Center in Baltimore, Maryland*, Baltimore, Maryland.

b. June 2005: The facility experienced a large-scale group disturbance in three separate units that required the intervention of the Baltimore City Police Department in order to restore order;[43]

c. July 2005: Six youths repeatedly kicked and punched a victim in the presence of staff without staff intervention;[44]

d. July 2005: Three youths repeatedly hit and kicked a victim, also in front of staff;

e. August 2005: One youth struck another youth several times in the face with a closed fist. The victim sustained injuries to his left eye, lip, neck, and shoulder. The victim's left eye was injured so severely that he can no longer see out of that eye. There was no staff intervention;[45]

f. September 2005: A youth assaulted another youth striking him several times in the face with a closed-fist. The victim sustained injuries to his left eye, which was swollen and bleeding, a laceration to the corner of his left eye and nose, a laceration on the lower lid of his left eye, a bloody nose, and injuries to the back of his head. There was no staff intervention;[46]

g. September 2005: A youth was placed in seclusion for over 24 hours. During the entire length of seclusion, cell checks were documented for only a two-and-a-half-hour period. A BCJJC report states that this is a well-known breach of protocol and creates a severe risk of self-harm and/or suicide;[47]

h. October 2008: A youth was placed in seclusion for over 24 hours. During the entire length of seclusion, cell checks were documented for only a two-and-a-half-hour period. A BCJJC report states that this is a well-known breach of protocol and creates a severe risk of self-harm and/or suicide.[48]

i. October 2009: A 17-year-old individual managed to escape from a juvenile treatment program in Baltimore County during a group outing to the cinema. The teenager spent the night at the residence of a female counselor from the facility, where they engaged in sexual activity.[49]

j. Unknown date: Inmates obtained matches and cigarettes to set off fire sprinklers to flood unit, then barricaded themselves inside- staff did not intervene for two hours.

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[43] *Id.*
[44] *Id.*
[45] *Id.*
[46] *Id.*
[47] *Id.*
[48] *Id.*
[49] *Id.*

83. Furthermore, there have been countless reports of other and ongoing pervasive failures to protect youth at the BCJJC. These include the overuse of unsafe restraint practices, failure to protect from harm of youth-on-youth violence, 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, inadequate fire safety within both facilities, and extensive environmental security hazards.[50]

84. These publications only scratch the surface of the physical abuse that has occurred within the facility, and wholly excludes the sexual abuse that has occurred at the BCJJC altogether.

85. The rampant sexual abuse within the facility is often underreported for a variety of reasons, including the grotesque nature of the facts as well as the unwillingness of the victims to come forward and share personal details of their abuse.

86. Many of the victims who experienced sexual abuse at facilities such as the BCJJC have not even shared the details of their abuse with those closest to them, such as family and friends.

87. Upon information and belief, incidents of physical and sexual abuse have continued at the BCJJC to this day.

88. This chronic failure to address and remediate the harms identified in reports, investigations, and publicized documents directly enabled the sexual and physical abuse of plaintiffs and left the victims of this abuse far more damaged than when they were committed to the facility.

[50] *Id.*

C. **The Abuse of Plaintiffs**

89. All prior paragraphs are restated herein by this reference.

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

91. Plaintiffs are former residents of the BCJJC detention facility.

92. In their time at the facility, no matter how short or how long, Plaintiffs underwent frequent overuse of solitary confinement, strip searches, beatings, unconstitutional restraints, sexual harassment, sexual assault, and worse.

93. Plaintiffs' experiences at the BCJJC have traumatized them for life and shaped their adult lives.

94. These plaintiffs were thrown into a facility meant to be a last resort and were irreparably harmed in doing so.

a. John Doe (BCJJC) 1

95. John Doe (BCJJC) 1 was a committed as resident at BCJJC from 2006-2007.

96. When John Doe (BCJJC) 1 was sixteen years old, a female perpetrator began sexually abusing and harassing him.

97. On multiple occasions, the perpetrator stood outside John Doe (BCJJC) 1's cell when no one else was around, making lewd comments toward him and yelling sexually explicit language at him.

98. After verbally assaulting him, the perpetrator entered his cell and forced him to remove his pants and underwear.

99. After stripping him, the perpetrator forcibly performed oral sex on him.

100. John Doe (BCJJC) 1 was forced to endure oral sex by the perpetrator at least six times in his cell.

101. The perpetrator eventually ramped up the abuse, forcing John Doe (BCJJC) 1 to penetrate her vaginally.

102. The perpetrator's abuse was not limited to John Doe (BCJJC) 1's cell; on multiple occasions, the perpetrator caught him in the shower, ripping the curtain open and forcing him to masturbate to completion in front of her.

103. The perpetrator was not the only staff member who assaulted John Doe (BCJJC) 1.

104. Another perpetrator forced John Doe (BCJJC) 1 to show him his genitalia.

105. The perpetrator threatened to take away John doe (BCJJC) 1's privileges, such as recreation or even the basic ability to leave his cell during free time if he disclosed the abuse to anyone.

b. John Doe (BCJJC) 2

106. John Doe (BCJJC) 2 was a committed as resident at BCJJC from 2011-2012.

107. John Doe (BCJJC) 2 was sixteen years old when he was assaulted by two separate perpetrators at the BCJJC.

108. Following a youth-on-youth altercation, John Doe (BCJJC) 2 was sent to the office of a commanding officer.

109. The perpetrator began the meeting by screaming at John doe (BCJJC) 2.

110. John Doe (BCJJC) 2 was scared for his life.

111. The perpetrator got close to John Doe (BCJJC) 2 and started patting his arms, slowly proceeding to rub his hand down the John Doe (BCJJC) 2's stomach into his pants, groping his bare genitalia.

112. John Doe (BCJJC) 2 was frozen with fear.

113. After groping John Doe (BCJJC) 2, the perpetrator violently grabbed John Doe (BCJJC) 2's penis and stimulated him before John Doe (BCJJC) 2 mustered the courage to push the perpetrator off and run away.

114. In another incident with the perpetrator, the perpetrator followed John Doe (BCJJC) 2 into the showers and watched him while he showered.

115. The perpetrator entered the shower area and groped John Doe (BCJJC) 2's bare bottom.

116. In an incident with another commanding officer, the perpetrator sequestered John Doe (BCJJC) 2 into his cell for the night, before returning and beginning to wrestle with him.

117. As they were wrestling, the perpetrator slid his hand under John doe (BCJJC) 2's clothing, groped his bare genitalia, and digitally sodomized him.

c. John Doe (BCJJC) 3

118. John Doe (BCJJC) 3 was a committed as resident at BCJJC for several months in 2009.

119. John Doe (BCJJC) 3 was sixteen years old when a female perpetrator began sexually assaulting him.

120. John Doe (BCJJC) 3 was under the perpetrator's care and guidance while at BCJJC; she was supposed to be providing him with counseling services.

121. During a counseling session, the perpetrator instructed John Doe (BCJJC) 3 to write her notes.

122. The perpetrator's requests graduated in severity, eventually asking John Doe (BCJJC) 3 to write sex scenes of what she and he would do together.

123. When John Doe (BCJJC) 3 was released from physical custody at BCJJC, but still under the supervision of Defendant, the perpetrator visited his home at nighttime, took off her underwear, and forced him to have sexual intercourse with her.

124. John Doe (BCJJC) 3 recalls that the perpetrator would do this to other boys at the BCJJC, and that she was well known for this behavior by staff and other youths alike.

d. John Doe (BCJJC) 4

125. John Doe (BCJJC) 4 was a committed as resident at BCJJC for 2 years.

126. John Doe (BCJJC) 4 was sixteen years old when he was committed to the BCJJC detention center.

127. Within his first 36 hours at the facility, John Doe (BCJJC) 4 was raped twice by two unidentified guards (collectively, the "Unidentified Perpetrators").

128. On his second evening at BCJJC, the Unidentified Perpetrators entered John Doe (BCJJC) 4's cell during dinner time, threw his food away from him, and beat him.

129. After beating him, the Unidentified Perpetrators sodomized/penetrated John Doe (BCJJC) 4.

130. John Doe (BCJJC) 4 screamed for help.

131. Meanwhile, another guard (the "Complicit Perpetrator") stood in the doorway watching these despicable acts take place.

132. Not only did the Complicit Perpetrator ignore John Doe (BCJJC) 4's pleas for help, he masturbated while watching the onslaught continued.

133. When their assault was finished, the Unidentified Perpetrators left the cell, leaving John Doe (BCJJC) 4 lying on the floor pleading for help.

134. The Unidentified Perpetrators returned shortly thereafter and sodomized/penetrated John Doe (BCJJC) 4 again.

135. Due to the injuries resulting from the repeated rapes by the Unidentified Perpetrators, John Doe (BCJJC) 4 underwent surgery to repair his rectum.

e. John Doe (BCJJC) 5

136. John Doe (BCJJC) 5 was a committed as resident at BCJJC for less than a year.

137. John Doe (BCJJC) 5 was fifteen years old when he was sexually assaulted at the BCJJC by an officer perpetrator.

138. On of John Doe (BCJJC) 5's duties while a detainee at the BCJJC was cleaning the showers.

139. On one occasion, while he was in the showers cleaning, the perpetrator, who was monitoring John Doe (BCJJC) 5, waited until John Doe (BCJJC) 5 was wet from the cleaning and then began wrestling with him.

140. While wrestling, the perpetrator removed his own clothes.

141. The perpetrator then removed John Doe (BCJJC) 5's clothes and raped him, digitally penetrating him and sodomizing him.

142. On another occasion, the perpetrator appeared behind him John Doe (BCJJC) 5 while he was walking in a hallway alone.

143. The perpetrator forced John Doe (BCJJC) 5 to undress and sodomized him in the hallway.

144. The perpetrator attempted to rape John Doe (BCJJC) 5 a third time, but only stopped because another individual walked into the area where they were at the time.

145. John Doe (BCJJC) 5 also endured sexual abuse by other inmates at BCJJC when he was fifteen years old when he got into a youth-on-you altercation with older inmates and they stripped his clothes, hung him upside down, and sodomized him with a broomstick repeatedly.

146. BCJJC staff took no action whatsoever.

f. John Doe (BCJJC) 6

147. John Doe (BCJJC) 6 was a committed as resident at BCJJC for less than 4 months in 2004.

148. John Doe (BCJJC) 6 was fourteen years old when he was sexually assaulted at the BCJJC.

149. A female perpetrator entered his room, grabbed his hands, and forced him to penetrate her with his fingers repeatedly.

150. After the assault, the perpetrator repeatedly told John Doe (BCJJC) 6 to "be ready when I come back" in an aggressive manner.

151. When the perpetrator returned, John Doe (BCJJC) 6 pushed her away and refused to penetrate her, forcing her away from him.

152. John Doe (BCJJC) 6 endured substantially similar encounters with the perpetrator on countless occasions.

V. JOINT AND SEVERAL LIABILITY

153. All prior paragraphs are restated herein by this reference.

154. Plaintiffs plead joint and several liability against all Defendants herein 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.

VI. RESPONDEAT SUPERIOR

155. All prior paragraphs are restated herein by this reference.

156. 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.

VII. IMMUNITIES

157. All prior paragraphs are restated herein by this reference.

158. 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.

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

VIII. LEGAL CAUSES OF ACTION

FIRST CAUSE OF ACTION: NEGLIGENCE

160. All prior paragraphs are restated herein by this reference.

161. At various relevant times, Defendant was required to appropriately manage, supervise, and treat youth involved in the juvenile justice system in Maryland.[51] 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.

162. 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.

163. 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 the BCCJS remains with Defendant, as assigned by the Legislature.

[51] *See* About (maryland.gov).

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

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

166. 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 abuse;

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

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

168. Defendant was also negligent in selecting and contracting with third party providers, whom it failed to properly vet to ensure suitability for the critical services to be provided.

169. The exact services those third parties were contracted to provide are currently unknown to Plaintiffs, who lack access to those contracts, but upon information and belief, such

services included direct supervision, personal protection and care of youth at Defendant's facilities such as the BCJJC.

170. These third-party providers breached the standards of care applicable to their services to youth, more specifically by hiring, failing to supervise, and continuously retaining unfit staff who perpetrated upon youth as set forth with specificity above.

171. The acts and omissions of any third-party providers selected and paid by Defendant are imputable to Defendant as principal/employer and holder of these non-delegable duties.

172. 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. R. Civ. Pro. Cir. Ct. 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.

SECOND CAUSE OF ACTION: NEGLIGENT HIRING, SUPERVISION, AND RETENTION

173. All prior paragraphs are restated herein by this reference.

174. 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 the BCJJC.[52] Md. Code, Human Services § 9-201 et seq.

175. Defendant directly hired individuals at executive levels to oversee, manage and operate juvenile justice facilities including the BCJJC.

176. In addition, Defendant selected and hired both direct employees and third-party agents and providers to oversee, manage, and operate the BCJJC.

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

178. 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 the BCJJC and other facilities under its control.

179. Defendant breached this duty and others by hiring, either directly or through third party providers, unqualified and incompetent executives, providers and staff with known criminal backgrounds and/or readily ascertainable histories of abusing youth in other facilities.

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

181. Defendant would have known of these providers' and 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.

[52] *See* ¶¶ 32-36.

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

183. Defendant breached this duty by failing to monitor and supervise their direct staff and the performance of third-party providers and their staff to ensure that sexual abuse was not occurring.

184. Defendant and/or its selected third-party providers breached this duty by failing to investigate complaints both by youth residents and by independent evaluators that staff and youth at the BCJJC and other facilities under their control were perpetrating sexual abuse upon residents, including Plaintiffs.

185. Defendant and/or its selected third-party providers each 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.

186. Defendant and/or its selected third-party providers breached this duty by continuously retaining both direct Defendant staff members and providers whom they knew or should have known had dangerous propensities and/or had sexually abused youth.

187. Each of these breaches violated Defendants' statutorily mandated duties and applicable standards of care, as well as standards of care applicable to the providers.

188. Defendant had the power to terminate its direct employees and, at minimum, power to terminate its contract with any third-party provider who failed to protect youth from sexual abuse.

189. Defendant failed to exercise this power and was negligent in both the supervision and retention of its direct employees and those of the third-party providers with whom it contracted.

190. Defendant failed to promptly terminate the contracts with its third-party providers despite actual or constructive knowledge of the sexual abuse the providers' staff were perpetrating upon youth, including Plaintiffs.

191. 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.

192. Had Defendant's selected third-party providers 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.

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

194. 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, past and continuing into the future;

b. Severe emotional stress; 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. Rule 2-702 and 2703(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.

THIRD CAUSE OF ACTION: NEGLIGENT FAILURE TO TRAIN AND EDUCATE

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

196. 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.

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

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

199. 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.

200. While Defendant was permitted to hire third- party providers to carry out its work, Defendant retained at all times a duty to ensure that the staff of third-party providers were properly trained in regard to protecting children from sexual abuse.

201. Because these duties originate by statute and at the direction of the Maryland Legislature, Defendant cannot fully abdicate the ultimate responsibility to protect minors in its care, even when it hires third -party providers.

202. Defendant or others acting on its behalf or under its direction or control (both direct and third-party providers), 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 its staff, /employees, and/or /agents (direct and third parties) on behaviors constituting sexual abuse by staff and/or among residents;

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

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

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

g. Failing to properly train or educate its staff, /employees, or /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.

203. 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.

204. 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, past and continuing into the future;

b. Severe emotional stress; 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. Rule 2-702 and 2703(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.

FOURTH CAUSE OF ACTION: GROSS NEGLIGENCE

205. All prior paragraphs are restated herein by this reference.

206. 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.

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

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

209. 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.

210. While Defendant was permitted to hire third party providers to carry out its work, Defendant retained at all times a duty to ensure that the staff of third-party providers were properly trained in regard to protecting children from sexual abuse.

211. Because these duties originate by statute and at the direction of the Maryland Legislature, Defendant cannot fully abdicate the ultimate responsibility to protect minors in its care, even when it hires third party providers.

212. Defendant or others acting on its behalf or under its direction or control (both direct and third-party providers), 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.

213. 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.

214. 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, past and continuing into the future;

b. Severe emotional stress; 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. R. Civ. Pro. Cir. Ct. Rule 2-702 and 2703(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.

FIFTH CAUSE OF ACTION: SEXUAL ASSAULT AND BATTERY

215. All prior paragraphs are restated herein by this reference.

216. 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. This was equally true in regard to direct hires and anyone employed by third party providers.

217. In turn, all third-party providers had a duty to hire and retain only qualified staff to serve youth in Defendant facilities.

218. Defendant and its selected third-party providers, separately and jointly, intentionally failed to act on literally decades of complaints and allegations both from youth residents and independent evaluators which informed them that numerous staff had, and were continuing to, perpetrate sexual abuse upon the youth in their care.

219. 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.

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

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

222. 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, past and continuing into the future;

b. Severe emotional stress; 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. Rule 2-702 and 2703(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.

SIXTH CAUSE OF ACTION: PREMISES LIABILITY

223. All prior paragraphs are restated herein by this reference.

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

225. 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.

226. Defendant knew or should have known of the risk that staff/employees/agents (either its direct hires, or those of its selected third-party providers) 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.

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

228. 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.

229. 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 (direct and those of its selected third-party providers) and/or residents who perpetrated upon Plaintiffs.

230. 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 (and others staffed by its selected third-party providers) prior to the actual sexual abuse of Plaintiffs, all of which made imminent harm foreseeable.

231. 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.

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

233. Defendant's conduct was wanton, malicious, or oppressive, or Defendant disregarded or exhibited reckless indifference to the foreseeable risks of harm and acted with ill will, hatred, hostility, a bad motive, or the intent to abuse its power.

234. 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, past and continuing into the future;

b. Severe emotional stress; 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. Rule 2-702 and 2703(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.

SIXTH CAUSE OF ACTION: ARTICLE 24 MARYLAND DECLARATION OF RIGHTS – SUBSTANTIVE DUE PROCESS

235. The proceeding paragraphs are incorporated as though fully set forth herein.

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

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

238. 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 the BCJJC.

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

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

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

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

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

244. 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. 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.

SEVENTH CAUSE OF ACTION: ARTICLE 24 MARYLAND DECLARATION OF RIGHTS – PATTERN AND PRACTICE (*LONGTIN* CLAIM)

245. The proceeding paragraphs are incorporated as though fully set forth herein.

246. 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.

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

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

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

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

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

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

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

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

255. 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. R. Civ. Pro. Cir. Ct. 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.

IX. JURY DEMAND

Plaintiffs respectfully demand a trial by jury on all issues so triable.

X. PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray for judgment against Defendant, jointly and severally, as follows:

A. Enter judgment against Defendants in favor of the Plaintiffs for a sum in excess of $30,000, jointly and severally;

B. For a trial by jury on all issues so triable;

C. That the costs, including expert witness fees, of this action be taxed against Defendants;

D. Pre-judgment interest and post-judgment interest;

E. For reasonable attorneys' fees as allowed by law; and

F. For such other and further relief as the Court deems just and proper.

This the 1st day of October, 2023.

Respectfully submitted,

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_____

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IN THE CIRCUIT COURT OF BALTIMORE COUNTY, MARYLAND

CLAUDIA MCCLAIN
and
John Does 1-10 (HS),

Plaintiffs, **Civil Action No. _____**

vs.

The STATE OF MARYLAND,
Acting by and through its agencies,
MARYLAND DEPARTMENT OF
JUVENILE SERVICES, and/or
DEPARTMENT OF HEALTH
(formerly the DEPARTMENT OF
HEALTH AND MENTAL HYGIENE);

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."

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

INTRODUCTION

The self-proclaimed mission of Maryland's Department of Juvenile Services ("DJS" or "the Department") is "to appropriately manage, supervise, and treat youth who are involved in the juvenile justice system in Maryland." The Department is "a child-serving agency responsible for assessing the individual needs of referred youth and providing intake, detention, probation, commitment, and after-care services," and its goals are to "[i]mprove positive outcomes for

justice involved youth, to only use incarceration when necessary for public safety, to keep committed and detained youth safe while delivering services to meet youth needs, to ensure a continuum of care for justice-involved youth that is age- and developmentally-appropriate, to build, value, and retain a diverse, competent, and professional workforce and to enhance the quality, availability, and use of technology to improve services for staff, youth, and families." Its Vision is simple: "Successful Youth, Strong Leaders, Safer Communities."

In executing its mission on behalf of the State, DJS is statutorily authorized to operate detention centers—like the Charles H. Hickey, Jr. School ("the Hickey School" or "Hickey")—where the State may involuntarily place boys and girls ages 12 to 20, while awaiting their adjudicatory hearing or placement in a treatment program. Through these centers, the State undertakes the complete care and control of literally every aspect of the lives of the children in its care, including their housing, supervision, personal protection, education, nurture, and rehabilitation. Children placed for treatment are there because they need re-direction, they need mentors, and they need training in new ways that will equip them for normalized life in society. Unfortunately, due to the Department's abysmal lack of management and oversight, thousands of youngsters have been harmed rather than helped as they became the prey of sadistic staff whom they could not escape. Having taken these children's liberty, the State then paid the personnel who relentlessly raped, sodomized, beat, threatened, and tortured them in nightmarish ways. All while turning a blind eye for decades.

No one listened and no one believed the captive youth. Instead, the abuse there was so systemic that many residents recount, "Did we tell? There was no one *to* tell…staff were all in it together." It is little surprise then, that numerous staff at the Hickey School had prior felony convictions and histories of using excessive force against juveniles.[1] Despite the numerous internal and external investigations that documented serious abuse throughout Maryland's juvenile

[1] U.S. Dep't of Justice Civil Rights Division, Investigation of the Cheltenham Youth Facility in Cheltenham, Maryland, and the Charles H. Hickey, Jr. School in Baltimore, Maryland, 6-7 (April 9, 2004).

justice system dating back to at least 1967, the State repeatedly failed to respond or protect the children in its care. Like a fungus, sexual exploitation proliferated in the dark environment fed by years of executive tolerance. It was bad enough that the staff and the supervisors failed. The ultimate failure and blame attaches to the top brass who could have prevented these injustices perpetrated (literally) by the justice system itself but lacked the will or courage to do so.

The cries of some as young as seven years old at the Hickey School were dismissed. Investigations and warnings were ignored. Recommendations and policy changes were not implemented. The entire system failed these youth, and got away with generations of abuse. But with the passage of the Child Victims Act of 2023, at last, the time has come for a measure of justice for these survivors and for public accountability that will bring darkness to light and spark the long-promised overhaul of the juvenile system, which until now, tragically, has never been a State priority.

PARTIES PLAINTIFF

1. Claudia McClain is an adult resident of Baltimore, Maryland who resided at the Hickey School in Baltimore County, Maryland at relevant times herein.

2. Plaintiffs John Does (HS) 1-10 are now adult residents and citizens of Maryland, who resided at the Hickey School in Baltimore County, Maryland at relevant times herein.

3. Plaintiffs John Does (HS) 1-10 file this Complaint under pseudonyms 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 these Plaintiffs and/or their families. These Plaintiffs are vulnerable to the mental or physical harms of such disclosure.

4. Plaintiffs are all persons who as minors were housed, detained or incarcerated within juvenile justice facilities at the times of the acts complained of herein. The Maryland Code, 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 breach that confidentiality.

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

6. Further, publication of the intimate and private material this case involves risks serious humiliation and embarrassment to these 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.

7. 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.

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

9. 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.

PARTY DEFENDANT

10. Defendant, the State of Maryland ("the State" or "Defendant"), enforces Maryland's laws through its Executive Branch, consisting of various officers and agencies as authorized by Maryland's Constitution and its laws. 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, which the State has effectuated through several different Departments or Agencies.

11. From 1969 to 1987, the Juvenile Services Agency within the Department of Health

and Mental Hygiene ("DHMH") was responsible for the management, supervision and treatment of youth who were involved in the juvenile justice system. DHMH was renamed the Department of Health in 2017.

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

13. In 1989, the State General Assembly established the DJS. DJS assumed responsibility for the management, supervision and treatment of youth who were involved in the juvenile justice system from 1989 to present.[2]

JURISDICTION AND VENUE

14. 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 1113 above. Each of those agencies conducts or conducted business in Baltimore County, Maryland during the relevant period.

15. Venue in this Court is proper under Md. Code, Cts. & Jud. Proc. § 6-201, because Defendant "carr[ies] on a regular business" in Baltimore County.

16. Venue in this Court is also proper under Md. Code, Cts. & Jud. Proc. § 6-202(8) because Plaintiffs bring negligence and constitutional claims "[w]here the cause of action arose" in Baltimore County, Maryland.

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

18. 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).

[2] Between 1995 and 2003 DJS operated under the name "Department of Juvenile Justice."

19. 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).

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

FACTUAL ALLEGATIONS

A. Structure and Background of the Maryland Juvenile Justice Detention System and the Charles H. Hickey, Jr. School

21. Maryland's formal juvenile justice system is nearly two centuries old, originating with the legislature's passage of "An Act to Establish a House of Refuge for Juvenile Delinquents" in 1830.[3]

22. The first "House of Refuge" became operational in December 1855 on Frederick Avenue in Baltimore City. In 1910 the "House of Refuge" was re-named "Maryland School for Boys." One year later, in 1911, the facility was closed and the operations of the Maryland School for Boys was relocated to a site northeast of Baltimore City.[4]

23. This site is the location of the facility now known as the Hickey School. Its current street address is 9700 Old Harford Rd, Parkville, MD 21234.[5]

24. The Hickey School has operated continuously at this location since 1911.[6] From 1911 through 1984 it operated under the name Maryland School for Boys. It was re-named the Charles H. Hickey, Jr. School in 1985.[7]

25. Several State Departments have held responsibility for the management and

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

[4] *Id.*

[5] *Id.*

[6] Charles H. Hickey, Jr. School, Dep't of Juvenile Services, https://djs.maryland.gov/Pages/facilities/Charles-H Hickey-Jr-School.aspx (last visited Sep. 13, 2023).

[7] *Id.*

operation of Maryland's juvenile detention facilities, including the Department of Education, the Department of Public Works, the DHMH, the JSA, and, since 1989, the DJS.[8]

26. In 1995, the Maryland General Assembly re-named DJS the "Department of Juvenile Justice."[9] DJS operated under this name until 2003, when the General Assembly reverted DJS back to its original name.[10]

27. 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.[11]

28. DJS currently oversees six juvenile detention centers, including the Hickey School: (1) Baltimore City Juvenile Justice Center, (2) Cheltenham Youth Detention Center, (3) Charles H. Hickey, Jr., School, (4) Alfred D. Noyes Children's Center (temporarily closed), (5) Lower Eastern Shore Children's Center, and (6) Western Maryland Children's Center.[12]

29. DJS also oversees four committed placement centers: (1) Victor Cullen Center, (2) Garrett Children's Center (temporarily closed), (3) the Green Ridge and Backbone Mountain Youth Centers, and (4) Silver Oak Academy (indefinitely closed).

30. DJS or its predecessors have operated additional juvenile detention and committed placement centers that are now closed, including, but not limited to, the Montrose School closed in 1988,[13] and the Thomas J.S. Waxter Children's Center closed in 2022.[14]

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

[9] 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).

[10] *Id.*

[11] Detention and Community Supervision, Department of Juvenile Services, https://djs.maryland.gov/Pages/detention/Detention-Community-Supervision.aspx (last visited Sep. 13, 2023).

[12] Maryland Office of the Attorney General Juvenile Justice Monitoring Unit, 2023 First Quarter Report (2023).

[13] 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).

[14] Maryland Office of the Attorney General Juvenile Justice Monitoring Unit, 2023 First Quarter Report (2023).

31. Youth may be detained in secure juvenile detention facilities like the Hickey School while awaiting an adjudicatory hearing for their alleged offense or while awaiting placement in a committed placement center. Youth may be detained in committed placement centers after an adjudicatory decision has been rendered.[15]

32. Historically, the Hickey School has functioned as both a detention facility and a committed placement facility.[16] Since 2005, the Hickey School has operated a detention facility for youth awaiting adjudication or placement in a committed placement center and has contracted with a private third party, New Horizons, to operate a commitment center for youth sex offenders.[17]

33. Historically, the Hickey School has housed at least as many as 550 youths at one time.[18] The detention facility is currently approved by DJS to house 72 youths;[19] however, the Hickey School population has frequently exceeded this approved limit.[20]

B. Constitutional and Statutory Obligations Require Protection of Children in the State's Custody

34. Defendant (including DJS) is subject to a litany of constitutional and statutory obligations requiring it to protect the children in its care from physical and sexual abuse.

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[15] *Id.*

[16] Greg Garland, Plans to close Hickey school questioned, *Baltimore Sun* (July 13, 2005) https://www.baltimoresun.com/maryland/bal-md.hickey13jul13-story.html.

[17] Charles H. Hickey, Jr. School, Dep't of Juvenile Services, https://djs.maryland.gov/Pages/facilities/Charles-HHickey-Jr-School.aspx (last accessed Sept. 14, 2023).

[18] Jeffrey A. Butts & Samuel M. Street, Youth Correction Reform: The Maryland and Florida Experience, 25 (1988) https://jeffreybutts.files.wordpress.com/1988/07/csyp-md.pdf.

[19] Maryland Office of the Attorney General Juvenile Justice Monitoring Unit, 2023 First Quarter Report (2023).

[20] *See, e.g.,* Maryland Office of the Attorney General Juvenile Justice Monitoring Unit, 2011 Annual Report (2023) (observing overcrowding as a major issue and noting that the Hickey School exceeded its DJS-set population capacity of 72 youths on 212 of 365 days during 2011).

35. The Eighth Amendment of the U.S. Constitution requires states to ensure the "reasonable safety" of confined juveniles,[21] and deliberate indifference to the substantial risk of sexual assault violates confined juveniles' right to freedom from cruel and unusual punishment.[22]

36. 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.[23]

37. In 1980, the U.S. Congress bolstered the constitutional rights of both adults and children confined in State institutions through its passage of the Civil Rights of Institutionalized Persons Act ("CRIPA"), enabling the U.S. Department of Justice to bring civil actions against [24]State facilities—including juvenile facilities—to ensure the constitutional and statutory rights of confined persons are protected while in State custody.[24]

38. The Maryland Constitution's Declaration of Rights provides similar protections to individuals in State custody.[25]

39. 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 residential program to provide "a safe, humane, and caring environment." [26]

40. Consistent with these statutory obligations, DJS has implemented regulations for state-operated residential facilities that ostensibly prohibit acts of abuse within state facilities,

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[21] *See Helling v. McKinney,* 509 U.S. 25, 35 (1993) ("The [Eighth] Amendment, as we have said, requires that inmates be furnished with the basic human needs, one of which is "reasonable safety."); *see also Youngberg* at 31516 ("It is cruel and unusual punishment to hold convicted criminals in unsafe conditions.").

[22] *Farmer v. Brennan*, 511 U.S. 825 (1994).

[23] *See Youngberg v. Romeo*, 457 U.S. 307, 315-24 (1982).

[24] U.S.C. § 1997a (allowing the Attorney General to institute a civil action when persons confined in a state institution are subjected to "egregious or flagrant conditions which deprive such persons of any rights, privileges, or immunities secured or protected by the Constitution or laws of the United States causing such persons to suffer grievous harm, and that such deprivation is pursuant to a pattern or practice of resistance to the full enjoyment of such rights, privileges, or immunities.").

[25] *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).

[26] HS § 9-227.

including the "physical injury of a youth by any employee under circumstances that indicate the youth's health or welfare is significantly harmed or at risk of being significantly harmed," and the "sexual abuse of a youth, whether or not physical injuries are sustained."[27]

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,"[28] and, on or before the first day of employment, the Department must complete "a federal and State criminal history records check" for each employee.[29]

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."[30]

43. Consistent with these statutory obligations for hiring and training, DJS implemented regulations establishing standards for 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."[31]

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

[27] Md. Code Regs. § 16.18.02.01-02.
[28] Md. Code, Hum. Servs. § 9-208(1).
[29] Md. Code, Hum. Servs. § 9-209(a)(1).
[30] Md. Code, Hum. Servs. § 9-207(e).
[31] Md. Code Regs. § 16.05.01.03(A).

(c) Applicable law and regulation."[32]

C. "All program staff shall be trained according to the standards set for the applicable position by the Maryland Correctional Training Commission."[33]

D. "The Secretary shall adopt and enforce a code of conduct for personnel of the Department,"[34] 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[.]"[35]

44. In 2003, the U.S. Congress passed by unanimous consent in both the House of Representatives and Senate the Prison Rape Elimination Act ("PREA") for the purposes of, "establish[ing] a zero-tolerance standard for the incidence of prison rape," "mak[ing] the prevention of prison rape a top priority in each prison system," "increas[ing] the accountability of prison officials who fail to detect, prevent, reduce, and punish prison rape," and "protect[ing] the Eighth Amendment rights of Federal, State, and local prisoners."[36] The PREA explicitly included juvenile facilities within its scope.[37]

45. Upon information and belief, over a period of decades, DJS and its predecessors have issued policies, trainings, and other material intending to establish standards and practices for the protection of children in the State's care from abuse.

46. Despite its constitutional and statutory obligations and guidance, its enacted regulations, and its policies, DJS has failed to prevent the systematic physical and sexual abuse of children within its facilities for decades.

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[32] Md. Code Regs. § 16.05.02.01(B).
[33] Md. Code Regs. § 16.05.03.01.
[34] Md. Code Regs. § 16.05.04.01.
[35] Md. Code Regs. § 16.05.04.02.
[36] 42 U.S.C. § 15602.
[37] 42 U.S.C. § 15609(7) ("The term 'prison' . . . includes . . . any juvenile facility used for the custody or care of juvenile inmates.").

C. Knowledge of Institutional Abuse within the Maryland Juvenile Detention System and the Hickey School

47. The physical and sexual abuse of children within Maryland's juvenile detention facilities is longstanding and pervasive.

48. In 1967, the U.S. Department of Health, Education and Welfare, the predecessor agency to the U.S. Department of Health and Human Services, conducted a review of Maryland's juvenile services system.[38] Its report described Maryland's juvenile detention facilities as, "too large," and recommended that the state "evaluate effective means of reducing the size of [its] institutions."[39]

49. In 1973, 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 recommended that Maryland's Training Schools, including the Hickey School, "be phased out and replaced by a variety of community-based facilities."[40]

50. In 1986, youth residents detained at the Montrose School, a now-closed Maryland juvenile detention facility, filed a class-action lawsuit against the state alleging that conditions within the school violated the civil and constitutional rights of its residents.[41] 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 and rape, and multiple youth suicides.[41]

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[38] 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)).

[39] *Id.*

[40] *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)). [41] *Id.* at 10.

[41] *Id*.

51. The State of Maryland announced its intention to close the Montrose School in September 1987 and the last youth left the facility in March 1988.[42]

52. But violence and abuse within Maryland's juvenile detention facilities was not isolated to the Montrose School.

53. In April 1988, the *Evening Sun* in Baltimore reported on the unusually high number of altercations involving staff and residents at the Hickey School, citing a previously unreleased study by the Maryland Health Department that found 800 Hickey School students had received injuries serious enough to require visits to the infirmary during 1987.[43] Additionally, the Maryland State Police investigated 10 accusations of child abuse at Hickey during the same period.[44]

54. In September 1990, University of Maryland law students observed girls detained in a female ward at the Hickey School with "scars, bruises and fairly deep cuts on their arms," and a detained girl lying on the floor in an empty concrete cell with only a blanket.[45] The girls reported to the visiting law students that the scars, cuts and bruises on their arms were caused by handcuffs and that girls were sometimes handcuffed to their beds.[46] The girls also reported being placed in seclusion for periods as long as five days and being subjected to strip searches by male security guards. These reports prompted a DJS investigation conducted in October 1990.[48] [47]

55. In 1991, following five superintendent changes in two years, and a report stating that children at the Hickey School "are at imminent risk of physical and emotional damage," Maryland privatized the operation of the facility through a three-year, $50-million contract with

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[42] *Id.* at 19-23.

[43] Michael Wentzel, Jail for Kids Punishment methods eyed as Hickey School Changes, *The Evening Sun* (April 25, 1988)).

[44] *Id.*

[45] Laura Lippman, State probes charge of girls' abuse at Hickey, Baltimore Sun (Oct. 17, 1990) https://www.baltimoresun.com/news/bs-xpm-1990-10-17-1990290143-story.html.

[46] *Id.*

[47] *Id.*

Rebound, Inc. (Rebound).[48]

56. Shortly after Rebound assumed responsibility for the operation of the Hickey School, Michael Myers, a Rebound counselor, reported that he was, "appalled by the conditions," he found when Rebound arrived at the Hickey School, stating that boys in the punishment unit were locked in individual cells for more than 20 hours a day.[49] Another volunteer at the Hickey School reported that prior to Rebound, "we used to have a lot of assaults by staff on children."[50]

57. Rebound's operation of the Hickey School was brief. In November 1992, DJS announced its intent to terminate its contract with Rebound after only 14 months.[51] DJS spokeswoman Carol P. Hyman summarized Rebound's tenure at the Hickey School, stating "there were problems." A Rebound spokesperson conceded, "[w]e struggled with just keeping a lid on the place, trying to prevent assaults and other incidents."[52]

58. Maryland continued its experiment with private operation of the Hickey School even after its termination of the Rebound contract. In May 1993, Maryland contracted the operation of the Hickey School to Youth Services International (YSI), a venture established in 1991 by the founder of Jiffy Lube in a failed attempt to win the original Hickey School contract awarded to Rebound.[53] YSI operated the Hickey School until March 31, 2004.[54]

59. YSI's operation of the Hickey School and other juvenile detention facilities in Maryland was marred by continued incidents of abuse.

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[48] Scott Shane, A rough road up from delinquency, at Hickey School, young offenders make progress, but will it matter?, *Baltimore Sun* (Oct. 11, 1992) https://www.baltimoresun.com/news/bs-xpm-1992-10-11-1992285002story.html.

[49] *Id.*

[50] *Id.*

[51] Sheridan Lyons, Hickey operator is ousted Move follows free-for-all at juvenile school, *Baltimore Sun* (Nov. 20, 1992) https://www.baltimoresun.com/news/bs-xpm-1992-11-20-1992325024-story.html.

[52] Jim Ross, Jail firm hopes to rebound in Citrus from troubles, Tampa Bay Times (Jan. 15, 1995) https://www.tampabay.com/archive/1995/01/15/jail-firm-hopes-to-rebound-in-citrus-from-troubles/.

[53] Laura Lippman, Jiffy Lube man is picked to run Hickey School Hindman denied contract in 1991, *Baltimore Sun* (May 5, 1993) https://www.baltimoresun.com/news/bs-xpm-1993-05-05-1993125008-story.html.

[54] Dan Fesperman, Hickey Turns a Violent Page, Baltimore Sun (Mar. 30, 2004) https://www.baltimoresun.com/maryland/bal-hickey0330-story.html.

60. In 1997, a young man filed a federal civil rights claim against YSI arising from an alleged sexual assault perpetrated against him by his roommate while in the custody of the Hickey School as a juvenile between November 10 and December 5, 1993.[55] He alleged that YSI violated his constitutional rights under the Eighth and Fourteenth Amendments and that YSI's negligence in its failure to train and supervise its employees led to his sexual assault.[56]

61. In 2000, four guards at the Victor Cullen Center, another Maryland juvenile detention facility operated by YSI, were charged with assaulting juveniles. Two others were charged with sexually abusing youths at the center. In 2001, at least six additional guards were terminated following allegations of physical assaults.[57]

62. In September 2002, YSI paid $792,470 to the State of Maryland to resolve claims arising from its alleged failure to provide training to its employees as required under the terms of its contract for the operation of the Hickey School.[58] The Hickey School settlement followed an earlier $600,000 settlement between YSI and the State of Maryland arising from YSI's operation of the Victor Cullen Center.[60]

63. The State's findings that led to the settlement with YSI are documented in a "performance audit" of YSI's operation and management of the Hickey School—including its failures to meet its contractual obligations—between April 2000 and May 2001.[59] The *Baltimore Sun* reported the findings: "In almost every case, the company failed to provide the required 40 hours of in-service training to staff members employed at the school before the contract. The audit found that of 108 existing employees, only one received full training while 34 got none at all.

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[55] *Burton v. Youth Services International, Inc.*, 176 F.R.D. 517, 519 (D. Md. 1997).
[56] *Id.*
[57] Michael Scarcella, State may shut Victor Cullen youth jail, *Baltimore Sun* (Nov. 22, 2001) https://www.baltimoresun.com/news/bs-xpm-2001-11-22-0111220237-story.html.
[58] Prison Legal News, YSI: Another Death, Another Settlement (June 15, 2003) https://www.prisonlegalnews.org/news/2003/jun/15/ysi-another-death-another-settlement/.
[59] Michael Dresser, Contract violations at Hickey settled, *Baltimore Sun* (Sep. 10, 2002) https://www.baltimoresun.com/news/bs-xpm-2002-09-10-0209100146-story.html.

Meanwhile, 14 percent of 58 new employees were put on the job before completing their 40 hours."[60] In addition to training failures, "[YSI] failed to provide adequate supervision and recordkeeping when juveniles were put on suicide watches," and "failed to fully staff 19 percent of the posts specified in its contract in fiscal 2000 and 24 percent in fiscal 2001."[61] The audit further suggested that the staffing shortages were directly related to use-of-force incidents at the Hickey School: "60 percent of 'incident reports' - detailing rule violations, use of force or similar matters - occurred on shifts that were short-staffed."[62]

64. Despite the observations of the State's performance audit, DJS allowed YSI to continue to manage and operate the Hickey School.

65. On May 29, 2003, Maryland's Independent Juvenile Justice Monitor issued a report to the Governor's Office for Children, Youth and Families documenting 20 cases of abuse and neglect at the Hickey School between January and May 2003.[63] The 20 cases included instances of both physical and sexual abuse and questioned the accuracy of the DJS's incident report database that purported to track child abuse, assaults, and use-of-force incidents within Maryland's juvenile detention facilities.[64] While the report revealed "approximately 2.5 documented assault/use-of-force type incidents at Hickey each day," it emphasized that, "there may be many other cases that go unreported by staff and youth for fear of retaliation."[65]

66. The following incident descriptions are quoted verbatim from the 2003 Independent Juvenile Justice Monitor report.

A. "On January 5, 2003, a youth set off the sprinkler system on Clinton Hall. Reportedly, the youth was forced to stay in his room to endure the deluge of

[60] *Id.*
[61] *Id.*
[62] *Id.*
[63] Philip J. Merson, Independent Juvenile Justice Monitor Special Report on Conditions/Incidents at the Charles Hickey School (May 29, 2003).
[64] *Id.* at 1.
[65] *Id.*

water while other youths were evacuated from the area. Staff subsequently pulled the youth from his room, slammed him against the wall and dragged him downstairs where the area was flooded, and the older youths were allowed to beat him up. The youths on the upper floor were forced to return to their rooms, wet, while staff persons came around and beat them with wet slippers."[66]

B. "On January 13, 2003 a staff person on Clinton Hall reportedly grabbed a youth by his arm, threw him into a bathroom, and the youth injured his back when he struck a sink."[67]

C. "On January 24, 2003 a youth awoled from the facility. He was brought back and a subsequent interview by a DJJ investigator revealed allegations that the youth had been having consensual sex with a female staff person on the detention unit, Clinton Hall."[68]

D. "On February 7, 2003 a youth was reported missing and located when he was involved in a car accident in Anne Arundel County. The youth was reportedly driving a car registered to a female staff person at Hickey. There were allegations that the youth and the staff person may be having sexual relations."[69]

E. "On March 29, youths on Mandella Hall were reportedly involved in a fight. Staff intervened in the fight and one youth reported that a staff slammed him to the floor, so he tried to break his fall with his hand and his wrist was fractured. . . . A review of the DJJ Incident Reporting Database revealed that an incident

[66] *Id.*
[67] *Id.* at 2.
[68] *Id.* at 2.
[69] at 3.

report labeled as a "youth on youth with minor/no injury" had been forwarded to DJJ from Hickey on 4/11, but a copy of the incident report at Hickey revealed the report was completed on 3/29 at 9:30 PM."[70]

F. "Youths on Roosevelt Hall allege that on April 4, April 13, and April 18 staff persons had beat them, forced them to hold a live electrical cord in the shower, allowed other youths to beat them, and prevented them from receiving the necessary medical care as a result of the beatings. Other staff persons were reportedly aware of the incidents but failed to notify the appropriate authorities. The youth felt they were forced to lie about their injuries in an effort to prevent retaliation from staff. In September of 2001, the Hickey School had terminated one of the staff persons accused of abuse in this incident after DJJ sustained an investigation of unnecessary use of force. The same staff person went to work at another private facility in Maryland, and that facility was forced to terminate the staff once DJJ found out he was working there. The staff person was then hired by DJJ in 2002, after completing a background check. He began working for DJJ and was also rehired by Hickey because the staff person was cleared to work for DJJ. The staff person resigned his position with DJJ and began working full time with Hickey as a group leader."[71]

G. "The writer reviewed a DJJ Incident Report on 5/12 that alleged a youth was previously sexually abused by staff in the Cheltenham Youth Facility while being detained there between 4/30 and 5/2/03. . .The youth's public defender wanted some preventative action taken and the youth was court ordered to the Hickey School."[72]

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[70] *Id.* at 4.
[71] *Id.* at 5-6.
[72] at 6.

67. Additional incident reports appear to have been redacted in full from publicly available versions of the 2003 Independent Juvenile Justice Monitor Report. Upon information and belief, earlier reports from the Independent Juvenile Justice Monitor describe similar patterns of abuse and excessive use of force.[73]

68. The Report concludes, "Youth in state care have the right to be safe and secure in their environment. If DJJ and the Hickey School are unable to ensure their safety, contingency plans must be activated by the Department of Juvenile Justice to care for these youths."[74]

69. No contingency plans were activated. Despite the observations and recommendations of the 2003 Independent Juvenile Justice Monitor Report, DJS failed to ensure the safety and security of children at the Hickey School in the months and years to come.

70. On February 6, 2004, a Hickey School staff member was charged with assault after allegedly striking a youth who had dropped his food tray.[75]

71. On February 23, 2004, a Hickey School staff member, William Devon Johns, was charged with assault after allegedly punching a student in the face.[76]

72. On April 9, 2004, the U.S. Department of Justice's Civil Rights Division published the findings of its investigation into conditions at the Cheltenham Youth Facility and the Hickey School in a 51-page report (the "DOJ Report").[77] The DOJ conducted its investigation pursuant to CRIPA and found, "major constitutional deficiencies" in both facilities' failure to protect youth from staff violence, unsafe restraint practices, youth violence, excessive isolation, and other abusive practices.

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[73] *Id*. at 8 ("Previous reports from this office and recommended corrective actions have not resulted in a satisfactory reduction in these incidents of abuse and assault. The patterns of abuse and excessive force continue.").
[74] *Id.* at 9.
[75] Dan Fesperman, Hickey Turns a Violent Page, *Baltimore Sun* (Mar. 30, 2004) https://www.baltimoresun.com/maryland/bal-hickey0330-story.html.
[76] *Id.*
[77] U.S. Dep't of Justice Civil Rights Division, Investigation of the Cheltenham Youth Facility in Cheltenham, Maryland, and the Charles H. Hickey, Jr. School in Baltimore, Maryland (April 9, 2004).

73. The following subset of incidents of physical abuse occurring at the Hickey School are quoted verbatim from the 2004 DOJ Report.

A. "In a March 2003 incident, a Hickey staff member, breaking up a youth-on youth fight, hoisted one of the youth in the air and 'slammed him to the floor,' injuring his left arm. The facility failed to inform the youth's parents, who filed a report with Child Protective Services after seeing a cast on their son's arm on visiting day a week later. Staff reports failed to describe any injuries to the youth. OPRA investigators described the incident as 'another example of [Hickey] staff trying to conceal incidents.'"[78]

B. "In a May 2003 incident, Child Protective Services found that a Hickey staff member struck a youth in the face, which another staff member witnessed."[79]

C. "In a May 2003 incident, a Hickey staff member assaulted a youth who refused to leave a school classroom. The staff member grabbed the youth around the neck and slammed him against the wall outside the classroom. The youth then threw a plastic chair towards the staff member, but missed him. The staff member slammed the youth to the ground, choking, punching and kicking him. During our visits, we observed injuries to the youth's face and neck."[80]

D. "In January 2004, the Maryland State Police filed criminal assault charges against two Hickey staff members for assaulting a youth. A police investigation revealed that the youth, upset because a routine staff search of his room left it in disarray with some items missing, kicked his door. A staff member then slapped the youth in the face with an open hand and attempted to wrestle him to the ground. Although two staff members attempted to intervene to stop the

[78] *Id.* at 6.
[79] *Id*. at 5.
[80] *Id.*

assault, another staff member grabbed the youth from behind and began striking him with a closed fist. The youth was left injured in his room for three hours before being seen by the nurse. Photographs taken by the nurse reportedly depict injuries to the youth's face and body consistent with being grabbed around the neck and being struck in the face."[81]

74. The DOJ Report makes clear that the examples of physical abuse cited in its pages are "representative of recurrent problems at the facilities and are not aberrational." Additionally, the DOJ Report found that "staff frequently fail[] to provide any detail regarding the incidents [of physical abuse]," and, "[t]he recurrent nature of the incidents reflects a lack of appropriate training, reporting, supervision, and quality assurance practices at Cheltenham and Hickey."[82]

75. In addition to a lack of appropriate training and supervision, the DOJ Report identified inappropriate hiring practices at Cheltenham and Hickey. The DOJ's investigation, "revealed that individuals with felony convictions and histories of excessive force against juveniles may, at times, be hired as staff members at these facilities." The DOJ investigators 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." The DOJ characterized these findings as, "quite obviously, entirely unacceptable." [83]

76. The DOJ investigation also identified instances of sexual abuse at both Cheltenham and the Hickey School. The Report's description of "inappropriate staff-youth relationships" is quoted in full:

A. "Our investigation revealed incidents of misconduct at both facilities in which female staff were found to have engaged in inappropriate relationships with male youth residents as young as 14 years old. For example, in June 2003, during an investigation of a physical assault by a staff member on a youth at

[81] *Id.*

[82] *Id.* at 6.

[83] *Id.* at 6-7.

> Hickey, the staff member admitted to sexual abuse of another youth. In February 2003, a missing youth was found driving a car registered to a female staff person at Hickey. In April 2002, a staff member resigned after it was revealed that she had engaged in sexual intercourse with a youth resident at Cheltenham. Relationships of this variety clearly violate the Constitution. Unfortunately, the facilities have failed to institute adequate measures to prevent incidents such as these from recurring."[84]

77. Beyond physical and sexual abuse by staff, the DOJ investigation identified myriad other ongoing and pervasive failures to protect youth at Cheltenham and the Hickey School. These included, the use of unsafe restraint practices, failure to protect from harm of youth-on-youth violence, 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.[85]

78. The DOJ Report concluded with a list of 27 remedial measures to "rectify the identified deficiencies and protect the constitutional and statutory rights of youth confined at Cheltenham and Hickey. The first remedial measure identified in the list is to, "[e]nsure that youth are adequately protected from physical violence committed by staff and other youth, and sexual misconduct by staff."[86]

79. The findings of the DOJ Report prompted DOJ to initiate a civil action against the State of Maryland related to the conditions it observed at Cheltenham and the Hickey School. The parties settled the matter on June 29, 2005. Underscoring the severity of DOJ's observations, the first substantive remedial measure appearing in the settlement agreement states: "The State shall

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[84] *Id* at 13.
[85] *Id.* at 5-47.
[86] *Id.* at 48.

take all reasonable measures to assure that youth are protected from violence and other physical or sexual abuse by staff and other youth."[87]

80. The 2003 and 2004 findings of the Independent Juvenile Justice Monitor and the Department of Justice involving the Hickey School are even more egregious in light of the abuse scandal that rocked the Maryland juvenile justice system in 1999.

81. In December 1999, the *Baltimore Sun* published a four-part series of articles based on its investigation of child abuse at Savage Leadership Challenge, one of three state boot camps in Garrett County, Maryland. The articles in the Bootcamp Series described the Savage Leadership Challenge as, "perhaps the nation's most violent [bootcamp]," and characterized the violence observed by its reporter and photographer over a five-month period beginning in October 1998 as, "routine."[88] The *Baltimore Sun* reported and photographed verbal and physical abuse of children as young as 14 in camp induction rituals as well as day-to-day life. The violence observed included guards throwing shackled children to the ground, and slamming children out of bed, against walls, and through glass windows as part of the bootcamp's process to "break the kids down, [and] build them up."[89]

82. Immediately following the publication of the *Baltimore Sun's* Bootcamp Series, Maryland Governor Parris Glendening announced investigations into the state's three Garrett County bootcamp programs stating, "[t]he State . . . cannot and will not permit the physical abuse of anyone, juvenile or adult, in any of our facilities. Violence will not be tolerated."[90]

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[87] Settlement Agreement at 5 *U.S. v. Maryland*, 1:05-cv-01772 (June 29, 2005).
[88] Todd Richissin, Why are you crying? Answer: 'My life, sir', *Baltimore Sun* (Dec. 5, 1999) https://www.baltimoresun.com/bal-bootcamp-part1-htmlstory.html.
[89] *Id.*; Todd Richissin, On graduation day, an illusion of hope, *Baltimore Sun* (Dec. 6, 1999) https://www.baltimoresun.com/bal-bootcamp-part2-story.html.
[90] Todd RIchissin, Probes target juvenile camps; Assaults on youth by state guards spur 3 more investigations; 'No excuse for abuse', *Baltimore Sun* (Dec. 8, 1999) https://www.baltimoresun.com/news/bs-xpm-1999-12-089912080144-story.html.

83. Within two weeks of the Bootcamp Series' publication, the bootcamps were shut down and the DJS Secretary and four other DJS officials were removed from office. Secretary Gilbert de Jesus, Assistant Secretary and Superintendent of Facilities Don Carter, and Assistant Superintendent Jeff Graham resigned at the request of Governor Glendening. DJS Deputy Secretary Jack Nadol refused to resign and was fired.[91]

84. Despite the impact of the Bootcamp Series on DJS leadership and the operation of the bootcamps themselves, DJS failed to take meaningful steps to eliminate similar abuse at other state facilities like the Hickey School, as evidenced by continued reports of physical and sexual abuse documented by the *Baltimore Sun* in 2001, the Independent Juvenile Justice Monitor in 2003, and the Department of Justice in 2004.

85. DJS resumed its direct operation of the Hickey School on April 1, 2004.[92] Upon resuming operations of the facility, DJS found, "an out-of-control wreck of a juvenile detention center where housing units reeked of urine, graffiti covered walls, and locks didn't work on the doors of the rooms of dozens of potentially dangerous offenders."[93] DJS Secretary Kenneth C. Montague, Jr. reported that he was, "shocked and surprised," and hadn't realized how bad things were at the Hickey School until YSI left, and conceded that DJS had not monitored its vendors' performance as aggressively as it should.[94] Only upon resuming responsibility for operation of the Hickey School did DJS learn that at least forty former YSI employees did not meet DJS's minimum

[91] Daniel LeDuc, Top Juvenile Officials Ousted Md. Probe Shows Teens Abused at Boot Camps, *Washington Post* (Dec. 16, 1999)
[92] Dan Fesperman, Hickey Turns a Violent Page, *Baltimore Sun* (Mar. 30, 2004) https://www.baltimoresun.com/maryland/bal-hickey0330-story.html.
[93] Jeff Barker, Conditions at Hickey shocked Md. Officials, *Baltimore Sun* (May 27, 2004) https://www.baltimoresun.com/maryland/bal-conditions0527-story.html.
[94] *Id.*

hiring standards,[95] and DJS officials reported that YSI personnel records for the 320member staff were missing.[96]

86. Just over a year after DJS resumed responsibility for operations at the Hickey School, on July 1, 2005, Maryland Governor Robert Ehrlich announced his intention to close the facility, describing conditions at the facility as, "intolerable," "a violation of constitutional rights," and "a living model in what a system should not become."[97]

87. Less than two weeks after Governor Ehrlich's announcement, DJS Secretary Montague clarified that only a portion of the school, a 130-bed long-term residential program for post-disposition youths would be closed by November 30, 2005.[98] A 72-bed detention center for pre-disposition youths, as well as a 26-bed program for youth sex offenders, would continue to operate indefinitely.[99] The detention center for pre-disposition youths remains in operation today as does a secure program for youth sex offenders operated by a private vendor, New Directions.[100]

88. Despite DJS's direct operation of the Hickey School and the reduction in size of its youth population, questions regarding DJS and its management of the Hickey School continued.

89. A June 22, 2007 Juvenile Justice Monitoring Unit Special Report regarding a May 2007 escape from the Hickey School recommended closure of the facility stating: "The Hickey campus resembles an adult prison – it was built to serve as a large congregate care "reform" or "training" school – this model has been known to be ineffective in rehabilitating youth or reducing recidivism for decades. The interior violates both federal and state standards for newly constructed

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[95] Jeff Barker, 40 employed at Hickey fail to make grade, *Baltimore Sun* (May 8, 2004) https://www.baltimoresun.com/maryland/bal-employees0508-story.html.

[96] Jeff Barker, Conditions at Hickey shocked Md. Officials, *Baltimore Sun* (May 27, 2004) https://www.baltimoresun.com/maryland/bal-conditions0527-story.html.

[97] Andrew A. Green, Oft-criticized youth facility to be closed, *Baltimore Sun* (July 1, 2005) https://www.baltimoresun.com/maryland/bal-te.md.hickey01jul01-story.html.

[98] Greg Garland, Plans to close Hickey school questioned, *Baltimore Sun* (July 13, 2005) https://www.baltimoresun.com/maryland/bal-md.hickey13jul13-story.html.

[99] *Id.*

[100] Charles H. Hickey, Jr. School, Dep't of Juvenile Services, https://djs.maryland.gov/Pages/facilities/Charles-HHickey-Jr-School.aspx (last visited Sep. 13, 2023).

facilities. Youth sleep in small locked cells with no furniture except for a bed and mattress. Beds are not suicide proof, and youth do attempt suicide in the facility. Rooms lack toilet facilities and youth must rely on staff to release them from locked rooms to use toilet facilities. There is no other way to describe the facility than to say it is a 'jail for children.'"[101] In no uncertain terms, the Special Report stated: "We believe no amount of renovations, no matter how extensive, will ever make the Hickey facility appropriate for the housing of youth."[102]

90. Only months later, on October 11, 2007, a Juvenile Justice Monitoring Unit Special Report regarding an escape from the Hickey School in September 2007 reiterated its recommendation to close the facility, choosing to simply quote its June recommendations in full.[103]

91. On December 13, 2007, the DJS Director of Detention, Chris Perkins, resigned from his position after a report issued by the Montana Department of Health and Human Services revealed that Perkins, "directly abused or neglected youth under his care," while running the military-style Swan Valley Youth Academy.[104]

92. Less than one month later, on January 12, 2008, reporting by the *Baltimore Sun* revealed that the Superintendent of the Hickey School, Wallis Norman, had previously resigned under threat of dismissal from a superintendent role at a juvenile detention facility for trying to hide allegations of assault made by an incarcerated youth in his care.[105] DJS did not remove Norman from his position as Superintendent.[106]

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[101] State of Maryland Office of the Attorney General Juvenile Justice Monitoring Unit, Charles H. Hickey, Jr. School Special Report (Oct. 11, 2007) (quoting State of Maryland Office of the Attorney General Juvenile Justice Monitoring Unit, Charles H. Hickey, Jr. School Special Report (June 22, 2007) https://www.marylandattorneygeneral.gov/JJM%20Documents/Hickey%20Special%20Report%20Final102507.pdf.

[102] *Id.*

[103] *Id.*

[104] Greg Garland, Juvenile services official resigns, *Baltimore Sun* (Dec. 14, 2007) https://www.baltimoresun.com/news/bs-xpm-2007-12-14-0712140084-story.html.

[105] Gadi Dechter, Head of Hickey forced out in Ga., *Baltimore Sun* (Jan. 12, 2008) https://www.baltimoresun.com/news/bs-xpm-2008-01-12-0801120147-story.html.

[106] Gadi Dechter, Chief of Hickey School to keep post, *Baltimore Sun* (Feb. 23, 2008) https://www.baltimoresun.com/news/bs-xpm-2008-02-23-0802230227-story.html.

93. In 2009, Tyra M. Greenfield, a counselor at the New Directions Program, a privately-run secure program for youth sex offenders operating at the Hickey School, was charged with sexual child abuse following an incident in which she had sex with a child in her care at her home following his escape from the Hickey School.[107]

94. Upon information and belief, incidents of physical and sexual abuse have continued to occur at the Hickey School to the present day.

95. From 2010 to the present day the Juvenile Justice Monitoring Unit within the Office of the Attorney General has issued quarterly reports on incidents within Maryland's juvenile detention facilities. These quarterly reports do not categorize incidents of staff physical or sexual abuse. However, the Reports document a troubling volume of incidents involving the restraint of youths as well as incidents of suicide ideation, gestures, attempts or behavior within the Hickey School and throughout Maryland's juvenile detention facilities.[108]

96. DJS knew of the incidents and reports described above, and others, and was aware that the Hickey School and its other facilities failed to meet the minimum conditions required for its facilities by the U.S. and Maryland Constitutions, its own authorizing statutes, and its own regulations and policies.

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

D. The Prevalence and Effects of Sexual Assault in Juvenile Facilities

98. On September 4, 2003, President George W. Bush signed PREA into law, following its passage by unanimous consent in both the U.S. House of Representatives and Senate. Incorporated

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[107] Ben Nuckols, Escaped Juvenile Had Sex with Counselor, *News 4 Washington* (Oct. 1, 2009) https://www.nbcwashington.com/news/local/escaped-juvenile-had-sex-with-counselor-police/1858044/.

[108] *See, e.g.,* Maryland Office of the Attorney General Juvenile Justice Monitoring Unit, 2011 Annual Report (2011) (reporting 254 incidents involving the restraint of youths and 66 incidents of suicide ideation, gesture, attempt or behavior at the Hickey School in 2011).

into the law is a detailed list of Congressional findings regarding the prevalence and consequences of sexual assault within U.S. carceral institutions.[109] 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."[110]

B. "Young first-time offenders are at increased risk of sexual victimization."[111]

C. "Most prison staff are not adequately trained or prepared to prevent, report, or treat inmate sexual assaults."[112]

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."[113]

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."[114]

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[.]"[115]

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[109] 42 U.S.C. § 15601.

[110] 42 U.S.C. § 15601(2).

[111] 42 U.S.C. § 15601(4).

[112] 42 U.S.C. § 15601(5).

[113] 42 U.S.C. § 15601(6).

[114] 42 U.S.C. § 15601(11).

[115] 42 U.S.C. § 15601(14)(D).

99. While undoubtedly accurate, Congress's findings do not adequately express the trauma and lasting consequences suffered by survivors of the Hickey School.

E. Abuse of Plaintiffs

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

101. **Claudia McClain** was 13 years old when she was placed at Hickey in or around 1987 for stealing bicycles and other minor offenses. Her first sexual experience was a rape by a male staff perpetrator shortly after her arrival. She was raped and sodomized over 15 times by staff perpetrators during her time at Hickey and other DJS facilities, often under threat that she would be placed "in the hole" (a room with only a mattress, where she was sometimes left naked for hours or days) if she resisted. Claudia recalls that some of her friends and co-residents within the institutions committed suicide as a result of similar sexual abuse. Claudia remembers lying in bed fearfully listening to the sounds of others being raped, and waiting for the key to her own room to turn as the perpetrators let themselves in, telling her she "knew what time it was." Claudia herself attempted suicide within these institutions was later committed to a medical center to treat her resultant mental disorders. To this day, Claudia is in treatment and hates men.

102. **John Doe 1 (HS)** was sent to Hickey at age 15 in or around 1985 after charges of auto theft. During his six- to eight-month stay, a male staff perpetrator first lured him with care packages of essential items such as soap, washcloths, candy, and incidentals. This perpetrator then began anally raping John Doe 1(HS) and demanding fellatio on a weekly basis. When John Doe 1 (HS) cried out, the perpetrator covered his mouth. He often threatened John Doe 1 (HS) that if he did not comply, or if he reported the abuse, he would be sent to "big jail." John Doe 1 (HS) lived in constant fear of not only this sexual abuse, but that the perpetrator might send him to the even worse scenario of adult prison. John Doe 1 (HS) recalls that other staff knew and covered for each

other's perverted acts so widely that the Hickey School was a "breeding ground" for sexual abuse of residents.

103. **John Doe 2 (HS)** was 14 years old in or around 2000 when he was placed in DJS custody pending transfer to a foster care home. Over the next two years, John Doe 2 (HS) was placed in various DJS facilities, including Cheltenham, Victor Cullen, and the Hickey School. He was raped and sodomized by male staff in these facilities several times a week for some 15 months, and was also and forced to engage in group sexual acts with other youth residents and perpetrators on multiple occasions. His perpetrators beat and threatened to kill their victims if they told. When John Doe 2 (HS) resisted, he was placed in a locked isolation room where he was left naked and deprived of food. When he courageously reported the abuse, his assailant learned he had done so, and the abuse escalated to the point John Doe 2 (HS) thought he would die, and wanted to die. Since his release, John Doe 2 (HS) has attempted suicide three times and remains in therapy.

104. **John Doe 3 (HS)** was placed at Hickey at age 15 in 2005, and was forcibly sodomized by a male staff perpetrator on more than 10 occasions. This perpetrator forced his penis down John Doe 3 (HS)'s throat to the point he could hardly breathe, and would force John Doe 3 (HS) to swallow his semen so no one would know. John Doe 3 (HS) would return to his room and vomit. He reported the sexual abuse to the infirmary nurse, but nothing was done to stop it or protect him. The perpetrator threatened to kill him and also threatened to harm his family or friends. John Doe 3 suffers depression and anxiety as a result of these incidents.

105. **John Doe 4 (HS)** was 14 years old when he was sent to Hickey in or around 1984 after participating in a store break-in. He was sodomized and masturbated by a male staff perpetrator over 15 times. The officer would often page John Doe 4 (HS) (and other residents) out of school for tasks such as buffing floors or cutting grass in order to get them alone, and would then assault them behind locked doors while instructing them to keep the abuse quiet. Other staff observed this practice but never seemed to question it, although John Doe 4 (HS) and his fellow residents lived in fear of being summoned. In addition to his physical injuries, John Doe 4 (HS)

suffers nightmares and depression, because "I'll never forget his face." He isolates himself and finds it hard to trust others.

106. **John Doe 5 (HS)** was placed at Hickey in or around 1995 at age 15 for an assault charge. During his 9-month stay, he was victimized by a female staff perpetrator who groped his genitals and demanded he penetrate her with his fingers. This perpetrator told John Doe 5 (HS) that no one would ever believe him if he told. This abuse and manipulation left John Doe 5 (HS) vulnerable to abuse from other older females later in life, as he normalized this behavior. To this day, John Doe 5 sees his perpetrator's face when he closes his eyes.

107. **John Doe 6 (HS)** was placed at Hickey in 1979 at age 15 for behavioral issues. He was sexually abused over 15 times by two separate male staff who forced him to undress, performed oral copulation and fondling of his and their genitals while variously threatening him with a longer sentence and loss of privileges if he did not comply. These perpetrators also bribed John Doe 6 (HS) with food to keep him quiet and to permit the continuation of abuse. John Doe 6 (HS) suffers ongoing guilt, shame, and depression from the abuse.

108. **John Doe 7 (HS)** was placed at Hickey in 2007 at age 14 after fighting and drug charges. During his 9-month stay, he was assaulted at least 10 times by an adult male staff member who masturbated him and penetrated him with his fingers. This has caused John Doe 7 (HS) long term emotional trauma.

109. **John Doe 8 (HS)** was placed at Hickey at the age of 12 in or around 2004 for assault and fighting in school. During his six-month stay, he was anally raped by three male staff separately on three occasions. Two of these staff accessed him at night in his bed, restrained him violently and covered his face with a blanket. John Doe 8 (HS) lived in constant fear that these acts would be repeated, because the lock on his door did not work. The third staff approached John Doe 8 (HS) in the shower and then raped him in his room. These perpetrators threatened to harm John Doe 8 (HS) if he did not keep the abuse a secret. John Doe 8 (HS) has contemplated

suicide and self-harm, and faces anger, trust issues, and depression as he attempts to move on with his life.

110. **John Doe 9 (HS)** was 14 when he was placed at Hickey on two occasions. Over the course of 9 months, he was abused more than 20 times by three male staff who grabbed his penis bare-handed, forced him to touch their penises, inserted their bare fingers in his anus, kissed him and bribed him with cigarettes. John Doe 9 (HS) says, "My door would be open at night…I could hear this happening to other boys, and there was nothing I could do to stop it. I live now in a prison inside my head…a life of pain, fear, loss, tragedy, shame, hospitalization for suicide attempts and chronic mental health issues as a result from my time and abuse at Hickey, the house of horrors."

111. **John Doe 10 (HS)** was 7 years old when he was placed at Hickey in 1962. On some 10 occasions, his male staff perpetrator pulled John Doe 10 (HS)'s pants down, spanked him, and forced John Doe 10 (HS) to sit on his lap bare-bottomed while the perpetrator had his own pants unzipped and genitals out. John Doe 10 (HS) recalls feeling the perpetrator's erect penis and wetness on his bottom. He says now, "I have been struggling all my life with the things that happened to me in those facilities."

112. As concisely stated by Maryland Attorney General Anthony G. Brown, "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."[116]

JOINT AND SEVERAL LIABILITY

113. 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.

[116] Maryland Office of the Attorney General, Attorney General's Report on Child Sexual Abuse in the Archdiocese of Baltimore Interim Public Release (April 2023) Redacted by Order of the Circuit Court for Baltimore City, 20 (April 2023).

RESPONDEAT SUPERIOR

114. 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

115. While Maryland has partially waived immunity under the Maryland Tort Claims Act as amended by Child Victims Act, Md. Code, State Gov't § 12-104(a), to the extent claims herein trigger any governmental immunities, damages are sought only under and up to the amount of insurance coverage available.

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

COUNT I: NEGLIGENCE

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

118. At various relevant times, Defendant was required to appropriately manage, supervise, and treat youth involved in the juvenile justice system in Maryland. It was responsible for all aspects of care, protection and services for youth in its custody, including but not limited to housing, provisions, education, nurture, care and personal safety and protection.

119. 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.

120. These duties and obligations are statutorily mandated and are non-delegable. Even though Defendant has, through the years, contracted with third party providers (such as YSI and Rebound) as agents for some of these services, the ultimate responsibility for oversight,

management and operations at all levels of the Hickey School remains with Defendant, as assigned by the Legislature.

121. These duties and obligations require Defendant to meet applicable standards of care for facilities such as the Hickey School under its operation and control.

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

123. 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 abuse;

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

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

125. Defendant was also negligent in selecting and contracting with third-party providers, whom it failed to properly vet to ensure suitability for the critical services to be provided.

126. The exact services those third parties were contracted to provide are currently unknown to Plaintiffs, who lack access to those contracts, but upon information and belief, such services included direct supervision, personal protection and care of youth at Defendant's facilities including, but not limited to, the Hickey School. *See* ¶¶ 55-58, *supra*.

127. These third-party providers breached the standards of care applicable to their services to youth, more specifically by hiring, failing to supervise, and continuously retaining unfit staff who perpetrated upon youth as set forth with specificity above.

128. The acts and omissions of any third-party providers selected and paid by Defendant are imputable to Defendant as principal/employer and holder of these non-delegable duties.

129. 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/or 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. P. 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 II: NEGLIGENT HIRING, SUPERVISION, AND RETENTION

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

131. 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 the Hickey School. *See* ¶¶ 41-43, *supra*; Md. Code, Hum. Servs. §§ 9-206 *et seq.*

132. Defendant directly hired individuals at executive levels to oversee, manage and operate juvenile justice facilities including the Hickey School.

133. In addition, Defendant selected and hired both direct employees and third-party agents and providers (such as YSL, Rebound, and possibly others) to oversee, manage, and operate the Hickey School.

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

135. 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 the Hickey School and other facilities under its control.

136. Defendant breached this duty and others by hiring, either directly or through third-party providers, not only unqualified and incompetent executives, providers and staff, but in some cases dangerous individuals with known criminal backgrounds and/or readily ascertainable histories of abusing youth in other facilities. *See* ¶¶ 66.F, 75, 85, *supra*.

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

138. Defendant would have known of these providers' and 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.

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

140. Defendant breached this duty by failing to monitor and supervise their direct staff and the performance of third-party providers and their staff to ensure that sexual abuse was not occurring.

141. Defendant and/or its selected third-party providers breached this duty by failing to investigate complaints both by youth residents and by independent evaluators that staff and youth at the Hickey School and other facilities under their control were perpetrating sexual abuse upon residents, including Plaintiffs.

142. Defendant and/or its selected third-party providers each had a duty to retain only safe and qualified staff/employees/agents to serve youth in their care, and to terminate any staff who sexually abused a youth.

143. Defendant and/or its selected third-party providers breached this duty by continuously retaining both its direct staff members and providers' staff/employees/agents whom they knew or should have known had dangerous propensities and/or had sexually abused youth.

144. Each of these breaches violated Defendant's statutorily mandated duties and applicable standards of care, as well as standards of care applicable to the providers.

145. Defendant had the power to terminate its direct employees and, at minimum, power to terminate its contract with any third-party provider who failed to protect youth from sexual abuse.

146. Defendant failed to exercise this power and was negligent in both the supervision and retention of its direct staff/employees/agents and those of the third-party providers with whom it contracted.

147. Defendant failed to promptly terminate the contracts with its third-party providers despite actual or constructive knowledge of the sexual abuse the providers' staff were perpetrating upon youth, including Plaintiffs.

148. 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.

149. Had Defendant's selected third-party providers 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.

150. The acts and omissions of Defendant's staff/employees/agents and those of third-party providers are imputable to Defendant.

151. 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/or 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. P. 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 III: NEGLIGENT FAILURE TO TRAIN AND EDUCATE

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

153. 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.

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

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

156. 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.

157. While Defendant was permitted to hire third-party providers to carry out its work, Defendant retained at all times a duty to ensure that the staff of third-party providers were properly trained in regard to protecting children from sexual abuse.

158. Because these duties originate by statute and at the direction of the Maryland Legislature, Defendant cannot fully abdicate the ultimate responsibility to protect minors in its care, even when it hires third-party providers.

159. Defendant or others acting on its behalf or under its direction or control (both direct and third-party providers), 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 its staff/employees/agents (direct and those of third parties) on behaviors constituting sexual abuse by staff and/or among residents;

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

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

E. Failing to properly train or educate its staff/employees/agent (both direct and those of third parties) on how to establish and maintain proper channels whereby residents could report abuse;

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

G. Failing to properly train or educate its staff/employees/agents (both direct and those of 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.

160. 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.

161. 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/or 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. P. 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 IV: GROSS NEGLIGENCE

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

163. 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. This was equally true in regard to direct hires and anyone employed by third party providers.

164. In turn, all third-party providers had a duty to hire and retain only qualified staff to serve youth in Defendant's facilities.

165. Defendant and its selected third-party providers, separately and jointly, intentionally failed to act on literally decades of complaints and allegations both from youth residents and independent evaluators which informed them that numerous staff had, and were continuing to, perpetrate sexual abuse upon the youth in their care.

166. 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.

167. As such, Defendant and its selected third-party providers, or one or more of them, were grossly negligent in failing to perform their statutorily mandated, nondelegable and assumed duties to protect Plaintiffs and other youth from sexual abuse.

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

169. 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/or 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. R. Civ. P. Cir. Ct. 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 V: PREMISES LIABILITY

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

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

172. 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.

173. Defendant knew or should have known of the risk that its staff/employees/agents (either its direct hires, or those of its selected third-party providers) 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.

174. Defendant had a specific and non-delegable duty to provide reasonable security

measures to eliminate conditions contributing to foreseeable harm such as sexual abuse.

175. 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.

176. 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 its staff/employees/agents (direct and those of its selected third-party providers) and/or residents who perpetrated sexual abuse upon Plaintiffs.

177. 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 (and others staffed by its selected third-party providers) prior to the actual sexual abuse of Plaintiffs, all of which made imminent harm foreseeable.

178. 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 its selected 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's 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.

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

180. Defendant's conduct was wanton, malicious, or oppressive, or Defendant disregarded or exhibited reckless indifference to the foreseeable risks of harm and acted with ill will, hatred, hostility, a bad motive, or the intent to abuse its power.

181. 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/or 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. P. 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 VI: ARTICLE 24 MARYLAND DECLARATION OF RIGHTS – SUBSTANTIVE DUE PROCESS

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

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

180. Those who engaged in repeated acts of sexual abuse against Plaintiffs acted under color of Maryland state law in their roles as staff/employees/agents, or in roles responsible for the management, oversight and operation of the Hickey School.

181. These individuals' actions occurred within the course of their duty and within the scope of their employment.

182. These individuals repeatedly violated Plaintiffs' rights under Article 24.

183. Defendant is vicariously liable for these individuals' violations of Plaintiffs' Article 24 rights under the doctrine of *respondeat superior* and other principles found in the Restatement (Second) of Agency.

184. Defendant therefore deprived Plaintiffs of their right to bodily autonomy under Article 24 when its staff/employees/agents repeatedly sexually abused Plaintiffs.

185. As a direct and proximate cause of Defendant's unconstitutional conduct, Plaintiffs were deprived of their substantive due process right to bodily autonomy.

186. 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/or 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. P. 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)

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

188. It is the custom and practice of the Defendant to permit its staff/employees/agents to violate children's substantive due process rights to bodily integrity by physically and sexually abusing them.

189. Defendant failed to properly train and supervise its staff/employees/agents to prevent those repeated Constitutional violations.

190. Defendant's failure to properly train and supervise its staff/employees/agents demonstrates a gross disregard for and deliberate indifference to Plaintiffs' Constitutional rights.

191. Defendant's failure to train and supervise staff/employees/agents is patently obvious from the repeated sexual abuse that Plaintiffs and other children in its facilities have experienced for decades.

192. Defendant's failure to train and supervise and its permitted patterns of practice within its facilities resulted in staff/employees/agents sexually abusing children.

193. Defendant's staff/employees/agents failed to report these incidents of reckless and intentional unlawful conduct, and Defendant lacked effective procedures to control or monitor those individuals who had a pattern or history of unlawful behavior.

194. Defendant caused its staff/employees/agents to believe that unlawful sexual abuse would not be aggressively, honestly, and properly investigated.

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

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

197. 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/or 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. P. 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.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs demand judgment against the Defendant in an amount to be determined by a jury, inclusive of all compensatory damages, punitive damages where allowed by law, and pre- and post-judgment interest, together with court costs, attorney's fees and expenses, and such further relief as the Court deems appropriate.

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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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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IN THE CIRCUIT COURT FOR BALTIMORE COUNTY, MARYLAND

JOHN/JANE DOES (MS) 1-5	)	
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	
The STATE OF MARYLAND, acting through its agencies, MARYLAND DEPARTMENT OF JUVENILE SERVICES, and/or DEPARTMENT OF HEALTH (formerly the DEPARTMENT OF HEALTH AND MENTAL HYGIENE),	)	**Civil Case No.:**
	)	
	)	**COMPLAINT**
	)	
	)	**Filed:**
	)	
	)	
	)	
Defendant.	)	

"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."

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

I. INTRODUCTION

The Department of Juvenile Services ("DJS" or "the Department") is "a child-serving agency responsible for assessing the individual needs of referred youth and providing intake, detention, probation, commitment, and after-care services," with a vision of creating "Successful Youth, Strong Leaders, [and] Safer Communities." The Department provides a laundry list of goals, including to "[i]mprove positive outcomes for justice-involved youth," to "only use incarceration when necessary for public safety," to "keep committed and detained youth safe while delivering services to meet youth needs," and to "build, value, and retain a diverse, competent, and professional workforce and to enhance the quality, availability, and use of technology to improve services for staff, youth, and families."

In the name of rehabilitation and reform, the DJS is statutorily authorized to operate centers such as the Montrose School ("Montrose" or "the School"), where the state may send juveniles who are involved in the criminal justice system and those who are already committed to the care of the DJS. Through the Montrose School, and other facilities like it, the State of Maryland accepts full control of every aspect of the children's lives, such as housing, rehabilitation, feeding, supervision, education, nurture, and, most importantly, personal protection. The DJS claims that the rehabilitation that it provides to the children within its facility walls is crucial to reform them into productive and fulfilled adult citizens, but in actuality, it locks them inside of a cage to become the prey of sadistic staff whom they cannot escape. Despite the cursory and superficial goals that the DJS claim to be their core tenants, the children that are involuntarily committed to facilities such as the Montrose School often leave far more damaged than when they entered.

The Montrose School opened in 1866 in Maryland as an industrial training school for girls. The School eventually became a coed facility for juvenile offenders in Maryland's criminal justice system with a mission to provide its residents with a wide range of programs designed to offer each child with something that is appropriate and meaningful to them. Despite these false promises, when a child was sent to Montrose, they found a crumbling, overcrowded, and understaffed facility haunted by an extensive history of physical and sexual abuse from staff and other youth residents alike that left them traumatized.

Montrose was infamous for its widespread institutional failures long before the Maryland State Legislature shuttered the facility's doors in 1988. While the school was well known for being an overcrowded custodial warehouse for juveniles, its overuse of solitary confinement became its trademark. The School's rampant use of isolation cells became so renown that when Montrose was

closed, a select group of newly released juveniles gave a piece of the solitary confinement cell's door to then Governor Schaefer as a reminder that they survived the horrors in the School.[1]

Public efforts to reform or close the Montrose School began long before its closure in 1988 but only gained momentum at the government level two decades prior to the School's closure. In 1967, the Federal Department of Health, Education, and Welfare first reviewed Maryland's juvenile system, including Montrose, finding an "overuse of institutionalization."[2] This review alerted the state government of the risks posed inside of the facility, subsequently leading to several additional reviews. In 1986, the Department of Health and Mental Hygiene ("DHMH"), at the request of the Maryland State Legislature, prepared a report on the feasibility and desirability of shutting down Montrose.[3] Amongst their findings, the DHMH found that "at least half of the youth [at Montrose] do not need to be there."[4] The following year, the Maryland State Legislature reached the conclusion that even with constant improvement, continued operations at Montrose could not be considered good public policy, and the facility was shut down.[5]

The Montrose School was shuttered due to a multitude of factors, such as the school's reputation for publicized incidents of suicide, self-harm, and physical and sexual abuse by both staff and youths at the facility; overuse of harsh punishments in lieu of proper mental health interventions such as solitary confinement, physical constraints, strip searches, and beatings; severely inadequate support structure and staffing; dangerous levels of overcrowding; and crumbling school facilities. In the end, closure of the school was still not enough, as far too many

[1] 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)).
[2] *Id.*
[3] *Id.*
[4] *Id.*
[5] *Id.*

children left the Montrose School broken, if at all. The rampant abuse and institutional failures of the school created a mental health crisis for the youths that were placed there, culminating in countless acts of self-harm and suicide attempts, which were only overshadowed by the multitude of children that succeeded. The grotesque abuse suffered by these children within the School occurred due to an unrelenting failure by the Maryland juvenile justice system in protecting the residents in the care of the Montrose School and other juvenile detention facilities throughout the state.

During the time that each Plaintiff was in the direct custody, care, control, and direction of the state at Montrose School, its employees, agents, and contractors exploited their positions of trust and authority to abuse Plaintiffs in horrific ways. Furthermore, these agents, employees, and contractors abandoned any duty they owed to Plaintiffs in protecting them from themselves, other youths, and adults at the facility. Plaintiffs were harassed; groped on their breasts, buttocks, and genitals; penetrated with fingers, objects, and other body parts; and forced to engage in oral sex. This abuse occurred throughout the facility, the cottages, and the premises as a whole. Victims who sought to come forward were coerced into silence through bribery, isolation, physical restraints, abuse, or worse. Plaintiffs, and other former residents in a similar situation, were wholly unable to seek help or redress for the injuries they sustained at Montrose until only recently.

This action seeks redress for the horrors and harms exacted on Plaintiffs and other who endured similar abuse for years while they resided at the Montrose facility; to recover damages for the abundant and lasting scars, both physical and mental, that Plaintiffs will be forced to carry for the rest of their lives; to punish the perpetrators; and to ensure that this abuse or any like it is never allowed again under the watch of the State of Maryland.

II. PARTIES

A. Plaintiffs

1. All prior paragraphs are restated herein by this reference.

2. Plaintiffs John/Jane Does (MS) 1-5 are men and women who, as children, were placed by the State of Maryland at the Montrose School in Baltimore County, Maryland. Plaintiffs are now adult residents and citizens of various states.

3. Plaintiffs John/Jane Does (MS) 1-5 file this Complaint anonymously under the pseudonyms of John/Jane Doe pursuant to agreement and stipulation of Maryland's Attorney General.

4. Plaintiffs are all persons who as minors were 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.

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

6. 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.

7. Additionally, the 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.

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

9. 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.

B. Defendant

10. All prior paragraphs are restated herein by this reference.

11. Defendant, the State of Maryland ("the State" or "Defendant") enforces Maryland's laws through its Executive Branch, consisting of various officers and agencies as authorized by Maryland's Constitution and its laws. 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.

12. From 1969 to 1987, the Juvenile Service Agency within the Department of Health and Mental Hygiene ("DHMH") was responsible for the management, supervision, and treatment of youth who were involved in the juvenile justice system. DHMH was renamed to the Department of Health in 2017.

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

14. In 1989, the State General Assembly established the 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."

III. JURISDICTION AND VENUE

15. All prior paragraphs are restated herein by this reference.

16. 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 12 - 14 above. Each of those agencies conducts or conducted business in Baltimore County, Maryland during the relevant period.

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

18. 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 Baltimore County.

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

20. 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 Government § 12-106(a)(2).

21. 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. Article § 5-117(b).

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

IV. FACTUAL ALLEGATIONS

A. Structure and Background of the Maryland Juvenile Justice Detention System and the Montrose School

23. All prior paragraphs are restated herein by this reference.

24. The current Maryland Juvenile Justice Detention System was established nearly two centuries ago with the Maryland State Legislature's passing of "An Act to Establish a House of Refuge for Juvenile Delinquents" ("the Act") in 1830.[6]

25. The first house of refuge created by the Act was located in Baltimore City and began operations in 1855.[7] Since then, dozens of similar facilities have been opened under the Act.

26. Through the Act, Defendant has been in control of and responsible for the multitude of state departments that have managed and operated the juvenile justice facilities located throughout the State.

27. Since the inception of the Juvenile Justice Detention System, a variety of different state departments have been responsible for the management and operation of these facilities. First was the Department of Education, then the Department of Public Works, then the Juvenile Services Administration within the Department of Health and Mental Hygiene, and finally, since 1989, the DJS.[8]

28. In 1995, the Maryland General Assembly re-named DJS the "Department of Juvenile Justice."[9] DJS operated under this name until 2003, when the General Assembly reverted DJS back to its original name.[10]

29. Within its broader mandate to manage, supervise, and treat youth who are involved in the juvenile justice system in Maryland, the DJS is responsible for the operation of Maryland's secure juvenile detention facilities through the juvenile justice departments within its control [11]

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[6] 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).
[7] *Id*.
[8] *Id*.
[9] 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).
[10] *Id*.
[11] Detention and Community Supervision, Dep't of Juvenile Services, https://djs.maryland.gov/Pages/detention/Detention-Community-Supervision.aspx (last visited Sep. 13, 2023).

30. DJS is currently the administrative agency of the State charged with setting standards for juvenile detention facilities that are operated both by DJS as well as private agencies.[12]

31. The standards reflect adherence to three critically important central purposes of juvenile detention; 1) to protect the public; 2) to provide a safe, humane, and caring environment for children; and 3) to provide access to required services for children.[13]

32. DJS has a statutory mandate to establish regulations that "prohibit [the] abuse of a child" in its residential facilities and require each DJS residential program to provide "a safe, humane, and caring environment."[14]

33. Despite its statutory obligations, enacted regulations, and policies, DJS has failed to prevent the systematic physical and sexual abuse of children within its facilities for decades.

34. 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.[15]

35. The Maryland Constitution provides similar protections to individuals in State custody.[16]

36. 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 residential program to provide "a safe, humane, and caring environment."

[12] Md. Code Ann., Hum. Servs. § 9-237.
[13] *Id.*, at (b)(1)-(3).
[14] HS § 9-227.
[15] *See* Youngberg v. Romeo, 457 U.S. 307, 315-24 (1982).
[16] *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).

37. 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,"[17] 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.[18]

38. DJS also 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."[19]

39. 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.[20] DJS regulations also govern the Departments 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."[21]

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."[22]

c. "All program staff shall be trained according to the standards set for the applicable position by the Maryland Correctional Training Commission."[23]

[17] Md. Code, Hum. Servs. § 9-237(b)(2).
[18] Md. Code, Hum. Servs. § 9-209(a)(1).
[19] Md. Code, Hum. Servs. § 9-207(e).
[20] Md. Code Regs. § 16.18.02.01-02.
[21] Md. Code Regs. § 16.05.01.03(A).
[22] Md. Code Regs § 16.05.02.01(B).
[23] Md. Code Regs. § 16.05.03.01.

d. "The Secretary shall adopt and enforce a code of conduct for personnel of the Department,"[24] 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[.]"[25]

40. Defendant, vicariously through the DJS and its predecessors, knew or should have known of the incidents and reports described herein, and others, and was or should have been aware that the Montrose School failed to meet the minimum conditions required for its facilities by the U.S. and Maryland Constitutions and its own authorizing statutes.

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

42. Montrose was opened in 1866 as an industrial training school for girls.[26]

43. Montrose underwent several name and classification changes until 1922, when it became a juvenile facility and began accepting both pre-adjudication and court commitment cases.

44. Montrose then held males under the age of 16 and females under the age of 18.

45. When Montrose was established as a dedicated juvenile facility, it was intended as treatment source of last resort for the youths placed under its control. Short of waiver to the adult system, placement in a training school was considered the most severe, and often most expensive, sanction available to a juvenile court in its handling of youth offenders.[27]

[24] Md. Code Regs § 16.05.04.01.
[25] Md. Code Regs. § 16.05.04.02.
[26] 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)).
[27] *Id.*

46. Through the Montrose School, Defendant accepted full control of every aspect of the children's lives, such as housing, rehabilitation, feeding, supervision, education, nurture, and personal protection.

47. Consistent with its statutory obligations, Defendant implemented regulations for state-operated residential facilities that ostensibly prohibit acts of abuse within state facilities, including the "physical injury of a youth by any employee under circumstances that indicate the youth's health or welfare is significantly harmed or at risk of being significantly harmed," and the "sexual abuse of a youth, whether or not physical injuries are sustained."[28]

48. In addition to the promise to protect and rehabilitate the children at Montrose, the facility sought to offer a "wide range of programs so that each child is offered something that is appropriate and meaningful to them."[29]

49. Despite the facility's cursory and superficial promises, Defendant has consistently failed to prevent the systemic physical and sexual abuse of the children within its care for decades.

50. When a juvenile was sent to Montrose, they did not find a center for rehabilitation. Rather, they found themselves trapped in an over-custodial warehouse rampant with physical and sexual abuse by sadistic youth and staff.

B. The Institutional Abuse Rampant Within the Juvenile Justice System and the Montrose School

51. The rampant physical and sexual abuse in the Montrose School plagues the entirety of the juvenile justice system throughout the State of Maryland.

52. Facilities such as the Baltimore City Juvenile justice Center, the Charles Hickey School, the Victor Cullen Center, the Montrose School, and more, are infamous for the horrors

[28] Md. Code Regs. § 16.18.02.01-02.
[29] *Id.*

experienced by those incarcerated there due to frequent review by state departments, publicized incidents of abuse, and testimonial from former residents.

53. In 1967, the U.S. Department of Health, Education and Welfare, the predecessor agency to the U.S. Department of Health and Human Services, conducted a review of Maryland's juvenile services system.[30]

54. The U.S. Department of Health, Education and Welfare's report described Maryland's juvenile justice system as, "an overuse of institutionalization" and recommended that "[s]erious thought should be given to establishing community-based programs for delinquent youth capable of being treated in the community." The federal reviewers noted that Maryland's juvenile institutions, including what was then the Montrose School for Girls, were "too large" and that the state should "evaluate effective means of reducing the size of [its] institutions."[31]

55. In 1973, the National Association for the Advancement of Colored People (NAACP) reached similar conclusions in its report examining conditions at Maryland's juvenile detention facilities.

56. The NAACP recommended that Maryland's Training Schools, including the Montrose School, "be phased out and replaced by a variety of community-based facilities."[32]

57. State department reviews of the Maryland Juvenile Justice system have found that the Maryland juvenile detention facilities have the highest rates of sexual abuse nationwide.[33] This alarmingly high rate of abuse indicates that detention facilities across the state have failed to

[30] *Id.*
[31] *Id.*
[32] *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)).
[33] Letter from The Civil Rights Division of The Office of the Maryland State Attorney General to Honorable Robert L. Ehrlich, Jr., 2006, *Investigation of the Baltimore City Juvenile Justice Center in Baltimore, Maryland*, Baltimore, Maryland.

protect youth inmates from sexual abuse, and that they may be liable for the damages suffered by survivors with potential claims.[34]

58. A 1986 study, conducted by the DHMH found that the Montrose facility, as well as other detention centers throughout the Juvenile Justice System, were geared towards custodial care rather than the treatment of juveniles.

59. The DHMH report found that the Montrose School specifically was "warehousing in the worst sense and absolutely contradictory to any philosophy of a human juvenile justice system."[35]

60. Since juvenile facilities such as Montrose were only reserved for the most severe of juvenile punishments, it would be expected that the residents of the facility were dangerous, hard-core juvenile offenders, but this was hardly the case. Rather, the youths at Montrose were largely status offenders, misdemeanants, and property offenders.

61. In 1986, the State estimated that 44% of the Montrose population had been incarcerated for violations of probation, most of which were for mere status offenses such as truancy or ungovernableness.[36]

62. When these non-violent offenders were committed to the Montrose School, they were not treated to rehabilitation. Instead, they found a crumbling, overpopulated, and understaffed facility that left them far more damaged than when they arrived.

63. The School was located on a campus surrounded by a number of cottages, designed to hold twenty youths each.

[34] Butts, *Youth Correction Reform: The Maryland and Florida Experience*, (1988).
[35] *Id*.
[36] *Id*.

64. Montrose was designed to be a 212-bed facility, but in actuality, it held on average, 250 residents at any given time.[37]

65. The campus cottages held around 25 to 30 youths in them on average, sometimes having as many as 45 youths in a single building.

66. The School suffered chronic overpopulation, and when the cottages reached a dangerous level of overcrowding, the staff set up cots in the hallways and basements of the School for the youth to sleep.

67. The problems created by the overcrowding of the facility were compounded by crumbling facilities and understaffing.

68. The buildings on Montrose's campus, including the cottages, were plagued with poor ventilation and heating, insect and rodent infestations, improper disposal of sewage both internally and externally, and widespread asbestos residue.

69. Understaffing was rampant, with staff working three to four double shifts per week in order to maintain staffing quotas at the facility.[38]

70. The living conditions that the youth were forced into, however horrid, were nothing in comparison to the staff, employees, and contractors that operated the facility.

71. When a juvenile was committed to the Montrose School, they found themselves locked in a cage of sadistic animals, willing to perform acts of physical and sexual abuse purely contradictory to basic human nature.

72. The staff was quick to institute severe physical punishment and frequent stays in isolation as a substitute for adequate behavioral control.

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[37] *Id.*

[38] See Picturethis43, *Montrose School Alumni?*, YouTube (Oct. 9, 2007) https://www.youtube.com/watch?v=t0duSEwA0PE.

73. Even when the youth were not misbehaving, staff would personally antagonize the residents with physical, mental, and often sexual abuse.

74. Juveniles at the Montrose School were subjected to beatings and a practice known as "body slamming" by the staff who were tasked with watching over them.[39]

75. The beatings were not confined to just hands, as staff would throw them to the ground, kick them, hit them with batons, throw chairs at them, and use any other objects at their disposal to inflict fear and pain upon them on a daily basis.

76. The staff at facilities like Montrose did not stop at mere beatings, as the male youth in the facility were subjected to juvenile gladiator rings for staff entertainment; perpetrators would pull groups of boys from their cottages at dawn, line them up on either side of a separation fence, place their bets on which boy they thought would win, and then sic the children onto each other like rabid dogs. The youth who refused to participate were beaten bloody nonetheless, either at the hands of other children or by the staff themselves.[40]

77. If the youth were not subject to beatings or grotesque trials by the staff, they were instead dragged away from their cells or common areas and thrown into solitary confinement for days, if not weeks, at a time.

78. The children would be stripped and thrown into an isolated holding cell with nothing but a stark mattress on the cement floor.

79. They were denied any access or communication to other humans throughout their stay in solitary confinement, the only interaction being the sliding of food through the metal grate of the door.

[39] *See* Butts, *Youth Correction Reform: The Maryland and Florida Experience*, (1988).
[40] *See* ¶¶ 106-118

80. Overuse of solitary confinement became such a staple at Montrose that when the facility was inevitably closed, three juveniles removed pieces of the door and gave it to the State Governor as a reminder that they survived the horrors of the facility.[41]

81. The youth at Montrose endured a variety of horrors during their time at the facility, the worst of which being the sexual abuse by staff.

82. State department reviews of the Maryland Juvenile Justice system have found that the Maryland juvenile detention facilities have the highest rates of sexual abuse nationwide.[42]

83. Montrose School staff forced themselves upon the children at the facility, groping, sodomizing, and raping them throughout the cottages and in the facility itself. Children were taken into private areas, such as hallways and offices, where the staff thought that no one could hear their screams.

84. Some children were even taken to offices just outside of the isolation cells, where they could hear the cries of the children inside of the cells while they were being sexually assaulted themselves nearby.

85. The rampant and horrific abuse within the facility in combination with the crumbling facilities created a mental health crisis for the youth population.

86. There are countless records of self-harm and suicide attempts. However, it was the children who were successful in their attempts that truly encapsulates how horrendous the facility was.

[41] Butts, *Youth Correction Reform: The Maryland and Florida Experience*, (1988).
[42] *Id*.

87. One boy, a twin, whose brother was also held at the facility, was sequestered to the isolation chamber for weeks. With no proper visitation checks by staff, it was not discovered that he had hung himself within the cell until long after he had died.[43]

88. This was just one of multiple suicides at the facility in less than three years.

89. The conditions of the facility and the multiple suicides became well known amongst the Baltimore County community. As a result, local law professors brought a class action suit against the Montrose School on behalf of the residents, alleging the denial of civil and constitutional rights by the facility.

90. The School also faced another lawsuit by the Sierra Club shortly after the class action suit, attacking the conditions of the facility and alleging improper disposal of internal and external sewage by the facility.

91. Neither lawsuit reached a conclusion as the Montrose School was shuttered by the State before any action could be taken.

92. Just prior to its closure, the DHMH initiated studies of its own into the Montrose School and prepared reports on the feasibility and desirability of closing the school in response to a growing public outcry for change. The report found crumbling facilities, overcrowding, understaffing, dangers posed to residents within the facility, and incidents of violence, self-harm, and suicide. [44] In the end, the Montrose School was shuttered for the very same reasons as those outlined in the DHMH report.

93. The students who were sentenced to Montrose suffered throughout their time at the facility, and their trauma continues to torment them to this day.

[43] *Id*.
[44] *Id.*

94. The closure of the School only cured a symptom. It did nothing to solve the plague underlying the entirety of the Maryland Juvenile Justice System to this day.

C. **Abuse of Plaintiffs**

95. In each case, Defendant's staff/agents/employees (the perpetrators described below) gained access to Plaintiffs by virtue of their confinement in Defendant's facilities.

96. The perpetrators exploited their positions of trust, power and authority over Plaintiffs to sexually abuse them.

97. Plaintiffs are former residents of the Montrose School. In their time at the facility, no matter how short or how long, they underwent frequent overuse of solitary confinement, strip searches, beatings, unconstitutional restraints, sexual harassment, sexual assault, and worse.

98. Plaintiff's experiences at the School have traumatized them for life and shaped their adult lives. These plaintiffs were thrown into a facility meant to be a last resort and were irreparably harmed in doing so.

a. Jane Doe (MS) 1

99. Jane Doe (MS) 1 was a committed as resident at Montrose for three years.

100. Jane Doe (MS) 1 was 14 years old when male employees began sexually abusing her at Montrose.

101. Jane Doe (MS) 1 was thrown into the isolation cell and a staff perpetrator stripped her, handcuffed her with each limb tethered to different corner of the bed, and vaginally raped her.

102. She was raped by the perpetrator at least 20 times while she was committed to the School.

103. Another perpetrator was tasked with transporting Jane Doe (MS) 1 into and outside of the facility.

104. On multiple occasions, when the perpetrator transported her, he forced her to perform oral sex on him.

105. The facility and staff, including the perpetrators, bribed Jane Doe (MS) 1 and the other girls at the facility with cigarettes to maintain their silence and reinforce good behavior.

b. John Doe (MS) 2

106. John Doe (MS) 2 was committed as resident for 7 months at the age of 13.

107. John Doe (MS) 2's abuse began during his first month at the facility.

108. John Doe (MS) 2 and his fellow detainees were woken up at dawn, taken out of their cottages, and lined up along the fences by staff members for their evaluation, akin to a cattle call.

109. The perpetrators threw money down onto a table, whispered amongst each other, and pointed towards the boys as they stood in front of them, frozen with fear.

110. Boys were then selected one by one to fight one another, in a gladiator type battle.

111. The fights left the boys, including John Doe (MS) 2, bruised and battered.

112. Even if the boys did not want to fight, the Perpetrators forced other boys beat them until they were left bleeding, nonetheless.

113. On other occasions, the perpetrators fought the young boys as well.

114. After several months in the facility, John Doe (MS) 2 encountered sexual abuse at Montrose as well.

115. John Doe (MS) 2 was repeatedly sexually assaulted by other perpetrators within the facility.

116. A perpetrator took John Doe (MS) 2 out of his room and forced him onto the bathroom floor.

117. The perpetrator began humming and gyrating on John Doe (MS) 2, forcing him to grab and stimulate his penis until ejaculation.

118. John Doe (MS) 2 was sexually abused in this manner at least six times during his stay at the facility.

c. John Doe (MS) 3

119. John Doe (MS) 3 was a committed as resident at Montrose from the ages of 13 to 14 years old.

120. John Doe (MS) 3 was under fourteen years old when he was sexually assaulted by a perpetrator at Montrose.

121. On more than ten occasions, the perpetrator pulled John Doe (MS) 3 out of his room around two or three o'clock in the morning, took him to a bathroom, and snuck the boy cigarettes as a bribe to keep him quiet.

122. After bribing him, the perpetrator forced John Doe (MS) 3 to expose his penis.

123. The perpetrator then forced himself on John Doe (MS) 3 and forcibly performed oral sex on John Doe (MS) 3.

d. Jane Doe (MS) 4

124. Jane Doe (MS) 4 was a committed as resident at Montrose for less than a year in 1984.

125. Jane Doe (MS) 4 was a twelve-year-old when she was placed in housing for troubled children at Montrose.

126. On over twenty occasions, a perpetrator took Jane Doe (MS) 4 out of her housing unit and directed her to the administrator's office.

127. The perpetrator then forced Jane Doe (MS) 4 to take off her clothes and to take off his own.

128. The perpetrator then fondled Jane Doe (MS) 4's breasts, genitals, and anus.

129. The perpetrator eventually penetrated Jane Doe (MS) 4 vaginally and anally and tried to put his penis in her mouth, only stopping when Jane Doe (MS) 4 refused to open her mouth, weeping and begging him to stop.

130. On occasions that the perpetrator stopped his attempts to put his penis in Jane Doe (MS) 4's mouth, he returned to raping her vaginally and anally.

e. Jane Doe (MS) 5

131. Jane Doe (MS) 5 was committed at the Montrose School from January to August of 1975.

132. Jane Doe (MS) 5 was under fifteen years old when she was abused at the Montrose School.

133. Her perpetrator took her from her cell under the guise of taking her to the infirmary so that he could pull her away from the other residents.

134. Once alone in the infirmary, the perpetrator would forcibly penetrate Jane Doe (MS) 5 both vaginally and anally repeatedly on multiple occasions.

135. This perpetrator was known for targeting children he knew would have no visitors and bribing them for their silence by putting money in their commissary accounts.

136. The perpetrator also blackmailed Jane Doe (MS) 5 with that commissary money for additional sexual favors; if she did not comply, he forced himself onto her regardless.

V. JOINT AND SEVERAL LIABILITY

137. All prior paragraphs are restated herein by this reference.

138. Plaintiffs plead joint and several liability against Defendant herein pursuant to Md. Code, Cts. & Jud. Proc. Code § 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.

VI. RESPONDEAT SUPERIOR

139. All prior paragraphs are restated herein by this reference.

140. 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.

VII. IMMUNITIES

141. All prior paragraphs are restated herein by this reference.

142. 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.

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

VIII. LEGAL CAUSES OF ACTION

FIRST CAUSE OF ACTION: NEGLIGENCE

144. All prior paragraphs are restated herein by this reference.

145. At various relevant times, Defendant was required to appropriately manage, supervise, and treat youth involved in the juvenile justice system in Maryland.[45] It was responsible

[45] *See* About (maryland.gov).

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.

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

147. 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 the Montrose School remained with Defendant, as assigned by the Legislature.

148. These duties and obligations required Defendant to meet applicable standards of care for facilities such as the Montrose School under its operation and control.

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

150. 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 abuse;

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

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

152. Defendant was also negligent in selecting and contracting with third party providers, whom it failed to properly vet to ensure suitability for the critical services to be provided.

153. The exact services those third parties were contracted to provide are currently unknown to Plaintiffs, who lack access to those contracts, but upon information and belief, such services included direct supervision, personal protection and care of youth at Defendant's facilities such as the Montrose School.

154. These third-party providers breached the standards of care applicable to their services to youth, more specifically by hiring, failing to supervise, and continuously retaining unfit staff who perpetrated upon youth as set forth with specificity above.

155. The acts and omissions of any third-party providers selected and paid by Defendant are imputable to Defendant as principal/employer and holder of these non-delegable duties.

156. 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. R. Civ. Pro. Cir. Ct. 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.

SECOND CAUSE OF ACTION: NEGLIGENT HIRING, SUPERVISION, AND RETENTION

157. All prior paragraphs are restated herein by this reference.

158. 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 the Montrose School.[46] Md. Code, Human Services § 9-201 et seq.

159. Defendant directly hired individuals at executive levels to oversee, manage and operate juvenile justice facilities including the Montrose School.

160. In addition, Defendant selected and hired both direct employees and third-party agents and providers to oversee, manage, and operate the Montrose School.

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

162. 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 the Montrose School and other facilities under its control.

[46] *See* ¶¶ 32-36.

163. Defendant breached this duty and others by hiring, either directly or through third party providers, unqualified and incompetent executives, providers and staff with known criminal backgrounds and/or readily ascertainable histories of abusing youth in other facilities.

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

165. Defendant would have known of these providers' and 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.

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

167. Defendant breached this duty by failing to monitor and supervise their direct staff and the performance of third-party providers and their staff to ensure that sexual abuse was not occurring.

168. Defendant and/or its selected third-party providers breached this duty by failing to investigate complaints both by youth residents and by independent evaluators that staff and youth at the Montrose School and other facilities under their control were perpetrating sexual abuse upon residents, including Plaintiffs.

169. Defendant and/or its selected third-party providers each 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.

170. Defendant and/or its selected third-party providers breached this duty by continuously retaining both direct Defendant staff members and providers whom they knew or should have known had dangerous propensities and/or had sexually abused youth.

171. Each of these breaches violated Defendant's statutorily mandated duties and applicable standards of care, as well as standards of care applicable to the providers.

172. Defendant had the power to terminate its direct employees and, at minimum, power to terminate its contract with any third-party provider who failed to protect youth from sexual abuse.

173. Defendant failed to exercise this power and was negligent in both the supervision and retention of its direct employees and those of the third-party providers with whom it contracted.

174. Defendant failed to promptly terminate the contracts with its third-party providers despite actual or constructive knowledge of the sexual abuse the providers' staff were perpetrating upon youth, including Plaintiffs.

175. 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.

176. Had Defendant's selected third-party providers 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.

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

178. 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, past and continuing into the future;

b. Severe emotional stress; 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. Rule 2-702 and 2703(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.

THIRD CAUSE OF ACTION: NEGLIGENT FAILURE TO TRAIN AND EDUCATE

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

180. 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.

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

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

183. 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.

184. While Defendant was permitted to hire third- party providers to carry out its work, Defendant retained at all times a duty to ensure that the staff of third-party providers were properly trained in regard to protecting children from sexual abuse.

185. Because these duties originate by statute and at the direction of the Maryland Legislature, Defendant cannot fully abdicate the ultimate responsibility to protect minors in its care, even when it hires third -party providers.

186. Defendant or others acting on its behalf or under its direction or control (both direct and third-party providers), 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 its staff, /employees, and/or /agents (direct and third parties) on behaviors constituting sexual abuse by staff and/or among residents;

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

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

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

g. Failing to properly train or educate its staff, /employees, or /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.

187. 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.

188. 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, past and continuing into the future;

b. Severe emotional stress; 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. Rule 2-702 and 2703(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.

FOURTH CAUSE OF ACTION: GROSS NEGLIGENCE

189. All prior paragraphs are restated herein by this reference.

190. 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.

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

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

193. 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.

194. While Defendant was permitted to hire third party providers to carry out its work, Defendant retained at all times a duty to ensure that the staff of third-party providers were properly trained in regard to protecting children from sexual abuse.

195. Because these duties originate by statute and at the direction of the Maryland Legislature, Defendant cannot fully abdicate the ultimate responsibility to protect minors in its care, even when it hires third party providers.

196. Defendant or others acting on its behalf or under its direction or control (both direct and third-party providers), 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.

197. 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.

198. 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, past and continuing into the future;

b. Severe emotional stress; 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. R. Civ. Pro. Cir. Ct. Rule 2-702 and 2703(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.

FIFTH CAUSE OF ACTION: SEXUAL ASSAULT AND BATTERY

199. All prior paragraphs are restated herein by this reference.

200. 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. This was equally true in regard to direct hires and anyone employed by third party providers.

201. In turn, all third-party providers had a duty to hire and retain only qualified staff to serve youth in Defendant facilities.

202. Defendant and its selected third-party providers, separately and jointly, intentionally failed to act on literally decades of complaints and allegations both from youth residents and independent evaluators which informed them that numerous staff had, and were continuing to, perpetrate sexual abuse upon the youth in their care.

203. 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.

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

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

206. 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, past and continuing into the future;

b. Severe emotional stress; 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. Rule 2-702 and 2703(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.

SIXTH CAUSE OF ACTION: PREMISES LIABILITY

207. All prior paragraphs are incorporated as though fully set forth herein.

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

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

210. 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 the Montrose School.

211. All the Perpetrators' actions occurred within the course of their duty and within the scope of their employment at the Montrose School.

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

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

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

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

216. As a direct and proximate result of Defendant's 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. 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.

SEVENTH CAUSE OF ACTION: ARTICLE 24 MARYLAND DECLARATION OF RIGHTS – PATTERN AND PRACTICE (*LONGTIN* CLAIM)

217. All prior paragraphs are incorporated as though fully set forth herein.

218. 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.

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

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

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

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

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

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

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

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

227. 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. R. Civ. Pro. Cir. Ct. 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.

IX. JURY DEMAND

Plaintiffs respectfully demand a trial by jury on all issues so triable.

X. PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray for judgment against Defendant, jointly and severally, as follows:

A. Enter judgment against Defendant in favor of the Plaintiffs for a sum in excess of $30,000, jointly and severally;

B. For a trial by jury on all issues so triable;

C. That the costs, including expert witness fees, of this action be taxed against Defendant;

D. Pre-judgment interest and post-judgment interest;

E. For reasonable attorneys' fees as allowed by law; and

F. For such other and further relief as the Court deems just and proper.

This the 1st day of October, 2023.

Respectfully submitted,

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**Pro hac vice forthcoming*
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IN THE CIRCUIT COURT FOR FREDERICK COUNTY, MARYLAND

JOHN DOES (VC) 1-8, inclusive,	:	
Plaintiffs,	:	
v.	:	
The STATE OF MARYLAND, acting through its agencies, MARYLAND DEPARTMENT OF JUVENILE SERVICES, and/or DEPARTMENT OF HEALTH (formerly the DEPARTMENT OF HEALTH AND MENTAL HYGIENE)	:	Civil Case No.:
	:	Filed:
	:	
	:	
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."

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

INTRODUCTION

1. This is the troubling tale of the widespread, documented abuse of juvenile offenders and youth with mental illness and substance abuse problems at a state-run juvenile detention center called Victor Cullen. It is a tale of rampant sexual abuse, perpetrated on Maryland's forgotten youth, investigated time and again -- only to be paid lip service by the state before the abuse began anew. It is a tale of unrelenting negligent failure by the State of Maryland and its agents and operatives to uphold their duty to children from troubled backgrounds, the vast majority of them

minorities and poor, with histories that required trauma-informed care – not the infliction of additional trauma.

2. Instead of viewing these youths as children in need of help, however, the staff at Victor Cullen thought of them as prey: animals, pieces of meat, less than human. In the showers, guards teamed up to hold the children down so their coworkers could rape them. At night, when children were supposed to be alone in their rooms, guards would come into the one place the children had a modicum of privacy and molest them, fondle them, masturbate them, and force them to engage in oral sex and vaginal intercourse when they were as young as 11 years old. The abuse was excruciating and violent: one child was forcibly anally penetrated while on the way to the medical unit; another was raped with such force that his abuser ripped the arms off a chair.

3. The abusers at Victor Cullen used intimidation and coercion to avoid being reported. While, at first, many victims were bribed to keep quiet with food, privileges, and preferential treatment, victims also saw the culture of abuse that viciously retaliated against anyone who reported. Children who thought about reporting were threatened with everything from additional time incarcerated to violence from both staff members and other children; children who went through with reporting saw those consequences come to life.

4. Plaintiffs file this Complaint to seek justice for the innumerable instances and ongoing pattern of humiliating, degrading, coercive and violent sexual abuse and other illegal treatment inflicted upon them while they were detained, or receiving alleged "treatment," as minor children at the Victor Cullen juvenile detention center in Sabillasville, Frederick County, Maryland.

5. For nearly 45 years, the State of Maryland and/or the Maryland Department of Juvenile Services, has owned, maintained, operated, supervised, and monitored the Victor Cullen

facility as a detention facility, "academy," camp and/or treatment center for youths generally aged 11 to 19, who were in trouble with the law or were deemed unmanageable due to mental health and/or substance abuse issues and needed treatment.

6. At some point while they were minors, each of the Plaintiffs was detained or otherwise housed at Victor Cullen for a period of months or, in some cases years, and through that detention the Plaintiffs were under the direct custody, care, control and direction of the State of Maryland through its agencies, currently the Department of Juvenile Services.

7. During the time that each Plaintiff was in the direct custody, care, control and direction of the State of Maryland through the Department of Juvenile Services and its other agencies at the Victor Cullen facility, its employees, agents, and contractors, used their positions of trust and authority to sexually abuse and control Plaintiffs.

8. Plaintiffs were abused in a multitude of ways, enduring repeated threats of violence and withholding of privileges and rights, the use of restraints and strip searches, multiple occasions of sexual touching, penetration and other forced acts by not just one predator but sometimes multiple predators, being treated like meat subject to the whims of depraved individuals who acted as though the victims were sexual playthings rather than young children entrusted into their care and custody.

9. This is an action to seek redress for the horrors and harms perpetrated on Plaintiffs and others who endured similar abuse; to recover damages for the abundant and lasting scars – physical and mental – the Plaintiffs have been left with; to punish the perpetrators and to make sure this sort of abuse is never allowed again under the State of Maryland's watch.

THE PARTIES PLAINTIFF

10. Plaintiffs are former residents or detainees of the Victor Cullen Center, a juvenile detention facility in Sabillasville, Maryland, operated by the State of Maryland through its agencies, including currently the Department of Juvenile Services. While they were in the direct care, control, and custody of the State of Maryland, they were all sexually abused, harassed, and exploited horrifically by the people who were entrusted with their care but treated them as animals.

11. Their collective abuse spans more than five decades, beginning in the early 1970s and continuing until as recently as 2019. At the time of their abuse, Plaintiffs were children ranging in age from 11 to 17.

12. Today, they are between 20 and 64 years of age.

13. Plaintiffs JOHN DOES (VC) 1-8 are now adult residents and citizens of various states, who resided at the Cullen Center in Frederick County, Maryland at relevant times herein.

14. Plaintiffs bring their claims pursuant to the Child Victims Act of 2023, which recognizes that the soul-crushing and sometimes physically debilitating legacy of childhood physical and/or sexual abuse lasts a lifetime.

15. Plaintiffs JOHN DOES (VC) 1-8 file this Complaint under the pseudonyms of John/Jane Does by agreement with and consent of 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.

16. Plaintiffs are all persons who as minors were housed, detained or incarcerated within juvenile justice facilities 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 breach that confidentiality.

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

18. Further, publication of the intimate and private material this case involves risks 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.

19. 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.

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

21. 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.

THE DEFENDANT AND ITS AGENCIES

22. Defendant, the State of Maryland ("the State" or "Defendant"), enforces Maryland's laws through its Executive Branch, consisting of various officers and agencies as authorized by Maryland's Constitution and its laws. 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.

23. From 1969 to 1987, the Juvenile Services Agency within the Department of Health and Mental Hygiene ("DHMH") was responsible for the management, supervision and treatment of youth who were involved in the juvenile justice system. DHMH was renamed the Department of Health in 2017.

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

25. In 1989, the State General Assembly established the Department of Juvenile Justice ("DJS") to assume 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." In 2003, the General Assembly reverted DJS back to its original name.

26. 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.

27. DJS currently oversees six juvenile detention centers, and four committed placement centers, Victor Cullen Center among them. Two additional centers have been closed.

JURISDICTION AND VENUE

28. 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 above. Each of

those agencies conducts or conducted business in Frederick County, Maryland during the relevant period.

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

30. 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 here.

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

32. This action arises from claims of sexual abuse as defined in Md. Code, Cts. and 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).

33. 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).

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

THE DUTIES OF THE DEPARTMENT OF JUVENILE SERVICES

35. DJS holds itself out as "a child-serving agency responsible for assessing the individual needs of referred youth and providing intake, detention, probation, commitment, and after-care services." According to its website, the Vision of the Department is, "Successful Youth, Strong Leaders, Safer Communities." The Goals of the Department are to "[i]mprove positive outcomes for justice-involved youth, to only use incarceration when necessary for public safety, to keep committed and detained youth safe while delivering services to meet youth needs, to ensure a continuum of care for justice-involved youth that is age- and developmentally-appropriate, to

build, value, and retain a diverse, competent, and professional workforce and to enhance the quality, availability, and use of technology to improve services for staff, youth, and families."

36. DJS is also the administrative agency of the State charged with setting standards for juvenile detention facilities that are operated both by DJS as well as private agencies. Md. Code Ann., Hum. Servs. § 9-237. The standards reflect adherence to three critically important central purposes of juvenile detention. These being 1.) to protect the public; 2.) to provide a safe, humane, and caring environment for children; and 3.) to provide access to required services for children. *Id*., at (b)(1)-(3).

37. Among the specific standards, there are provisions that seek to eliminate the unnecessary use of detention, establish population limits for juvenile detention facilities, sets staffing ratios; provide for staff qualifications and training to recognize and report child abuse and neglect; protect a juvenile's right to privacy; prohibit excessive force against a child and impose auditing and monitoring of programs and facilities. *Id*., at (c)(1)-(12).

38. DJS is 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 residential program to provide "a safe, humane, and caring environment."

39. 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,"90 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.

40. 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."

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

42. Despite its obligations, and in violation of state law and its own regulations, DJS knew of the incidents, reports, and culture of abuse at the Cullen Center during its years of operation but failed to meet the minimum conditions required for its facilities by the U.S. and Maryland Constitutions and its own authorizing statutes.

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

THE STATE'S COMMITMENT TO THE PREVENTION OF THE ABUSE OF JUVENILES IN ITS FACILITIES

44. 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.

45. The Maryland Constitution provides similar protections to individuals in State custody, including juveniles.

46. In addition to the federal and state Constitutions, there can be no question that one of our state's greatest moral obligations is to the prevention of child abuse and the protection of children from all forms of abuse, but particularly sexual abuse. This is why Maryland mandates that anyone who suspects abuse or neglect has an obligation to report that suspicion and provides

immunity to them for acting in good faith with that obligation. See Md. Code Ann., Family Law § 5-702. In addition, like many states, Maryland specifies that certain professionals and workers must report whenever they have a reason to believe that a child has been subjected to abuse or neglect. *Id*., at 5-704(a).

47. Staff members in a juvenile detention center are expressly among those positions that must report such abuse to the head of their institutions, being required to make both an oral report as well as a written report to their appropriate department and law enforcement agencies and officers.

48. Over the last several decades, amid repeated reports of abuse at several detention centers, the State has conducted numerous investigations into DJS operations.

49. In the 2000s, following a series in the Baltimore Sun, a Juvenile Justice Monitoring Unit ("JJMU") was established within the Office of the Maryland Attorney General. From 2010 to the present day the JJMU has issued quarterly reports on incidents within Maryland's juvenile detention facilities. These quarterly reports do not specifically categorize incidents of staff physical or sexual abuse. However, the reports have documented a troubling volume of problems such as the excessive use of restraints on children, strip searches, programmatic failures, and incidents of suicide ideation, gestures, attempts or behavior throughout Maryland's juvenile detention facilities, including the Victor Cullen Center.

THE VICTOR CULLEN CENTER

50. The Victor Cullen Center was built in 1907 as the first state-funded tuberculosis sanatorium in Maryland, called Hilltop State Hospital. Nestled between the mountains of western Maryland, the facility was later renamed in honor of Dr. Victor F. Cullen, a specialist in the treatment of tuberculosis who ran the Center with "great economy." In 1965 the building was

repurposed into a "reform school" for boys – and its long history as a place of healing and recovery soon came to an end.

51. In 1967, the U.S. Department of Health, Education and Welfare conducted an investigation of the Maryland juvenile detention system, finding it "too large" and marked by "an overuse of institutionalization," leading to the first of what would be many recommendations for Maryland to establish community-based programs for delinquent youth capable of being treated in the community.

52. In 1973, the NAACP Legal Defense and Educational Fund struck the same themes, warning that Maryland's secure training schools confined too many children who did not belong in secure detention and recommending that the large training schools like Victor Cullen be "phased out and replaced by a variety of community-based facilities.

53. By 1974, Victor Cullen had a reputation for wayward teenaged boys escaping the facility. In response to complaints from the neighboring community, the state shut Victor Cullen down.

54. In 1991, however, the state, grappling with how to handle its juvenile offender population, hired Youth Services International to reopen Victor Cullen as a boot camp-style facility that somehow was also supposed to provide treatment for mental health issues and addiction.

55. The juvenile detention facilities in Maryland which were operated by YSI and/or its associated or successor entities including Correctional Services Corp. ("CSC"), were known for unyielding brutal punishment.

56. A series in the Baltimore Sun in 1999 described the abusive tactics in detail including reports of juveniles assaulted routinely, even at times while shackled and unable to resist or protect themselves in any way.

57. It took so long for these illegal and damaging practices to come to light because there were so few institutional protections in place – first, to prevent abuse and second, to make sure injuries to children at Victor Cullen and other detention facilities were being properly reported.

58. In 1999, an investigation by the Baltimore Sun found that more than 200 reports of physical abuse had been altered, destroyed or simply not filed at Victor Cullen.

59. In December 1999, then-Gov. Parris Glendening shut down Maryland's boot camps, proclaiming, "Violence will not be tolerated." The state secretary of juvenile justice and other top officials lost their jobs. The Governor indicated a new day had arrived in Maryland's juvenile justice system.

60. But by June of 2000, escapes from Victor Cullen continued. So did reports of staff-on-resident violence.

61. Two teenagers at Victor Cullen rappelled from their third-floor holding cell window using clothing and bed linens. They were apprehended four hours later and returned before Victor Cullen staff ever noticed they were missing – despite the secure facility's duty to check on residents every fifteen minutes 24 hours a day.

62. In 2001, follow-up stories in the Baltimore Sun revealed that 124 youths from Victor Cullen had been treated at Frederick Memorial Hospital, most for "altercations" with employees of the facility. Their injuries included excessive bleeding from a nose, pain and tingling in an arm and should, "teeth went into lip," and numerous suicide attempts.

63. Yet another investigation at Victor Cullen verified that staff in the Silver Charm Cottage, which housed boys with substance abuse problems, ran a gladiator-style "Saturday Morning Fight Club," which pitted teens with addictions against one another to settle disputes – and entertain the staff.

64. One of the staff members responsible had been hired to care for young men with substance abuse issues despite a criminal history of selling drugs himself.

65. Rather than own the problem, Maryland's new secretary of juvenile services, Bishop Robinson, went on the offensive, claiming that the reports of abuse and impropriety were overblown. He claimed only two young men had been treated at Frederick Memorial Hospital. In fact, only two hospital visits had been paid for by Victor Cullen; the rest were paid by the children's insurance.

66. Among those calling for the creation of a citizens' oversight committee were Secretary Schiraldi, then-executive director of a non-profit devoted to juvenile justice issues: "It's extremely disappointing that the administration is spending its time trying to discredit reports of the violence rather than working to end it, especially when it's pretty well accepted by everybody involved that those facilities are loaded with problems."

67. Again, promises were made; change did not follow.

68. A two-year study at two other Maryland juvenile detention centers found evidence of frequent beatings and abuse of many boys by staff members and other youth. The study resulted in a report that found the facilities failed to meet minimum constitutional standards for such basic state-required services as suicide prevention, medical treatment and mental health care.

69. In 2007, the Maryland legislature determined that the state's juvenile detention facilities including Victor Cullen were too large -- the same thing that the US Department of Health

Education and Welfare had found in the 1960s, and the NAACP found in the 1970s. The legislature imposed new caps on enrollment to create smaller community-based facilities, which in turn were supposed to reduce violence and recidivism.

70. Victor Cullen's population was capped at 48 beds and the center because a regional hardware secure treatment center for male youth.

71. Even as the legislature was attempting to reform the state juvenile justice system yet again, the director of detention for the Department of Juvenile Services had to step down barely seven months into his position after acknowledging he had been associated with abuse of children at a Montana boot camp.

72. In 2009, of the committed youth who left state custody, 60 percent were re-arrested within a year. At Victor Cullen, 85 percent were re-arrested, convicted or "graduated" into the adult correctional system.

73. But once again, Victor Cullen and other juvenile facilities fell from the headlines, and the negligent management of the facility led to more violence, and a quiet epidemic of sexual abuse.

74. Between 2010 and 2020, the Maryland Juvenile Justice Monitoring Unit reported on conditions and incidents at Cullen.

75. Between 2014 and 2020 - the only years for which complete data is public - on average, each youth housed at Cullen was forcibly restrained between four and ten times.

76. In 2016, one JJMU report detailed an incident in which a staff member bribed two boys to attack one another. Other staff saw the situation occur yet failed to intervene.

77. In 2017, another JJMU report described a staff member having to be restrained from punching a young resident.

78. In 2018, there were 14 youth-on-youth assaults in the first quarter of the year.

79. A riot by detainees at Victor Cullen resulted in eight young men arrested, new enrollment halted – and a scathing report by the state finding that implicated staff in the riot rather than the young men they were supposed to be supervising.

80. A new director of the facility was installed following the riot, and in January 2019, Victor Cullen Center received recognition from the American Correctional Association and the Commission on Accreditation for Corrections after a three-day review in October. The new director, John Plummer, said much had been improved to enhance security and the overall experience for the teen males in the program. Director Plummer said the main physical change was putting locking systems on the doors, but the program expanded activities "exponentially."

81. But again, problems persisted.

82. In 2020, a former female employee of Victor Cullen was charged with sex abuse of a minor. The 33-year-old woman was accused of initiating sexual contact with a 17-year-old in the treatment program at the facility on six or seven occasions. When he was released, she contacted him on social media, and picked him up from his home on two occasions and drove him to a location where they engaged in sexual intercourse.

DEFENDANT'S SEXUAL ABUSE OF THE PLAINTIFFS

ABUSE OF JOHN DOE (VC) 1

83. Plaintiff JOHN DOE (VC) 1 was a resident of Cullen when he was 13 years of age. His abuse began in 2001, carried out by an employee of the facility who served as a counselor to the boy. The guard would often enter JOHN DOE (VC) 1's room during the evenings and touch JOHN DOE (VC) 1's genitals underneath his underwear and then perform oral sex on him until JOHN DOE (VC) 1 ejaculated. To ensure that JOHN DOE (VC) 1 would not report her actions,

she would bring him cigarettes and steak and cheese sandwiches and allow him to use her phone. JOHN DOE (VC) 1 recalls this happening on at least 20 occasions and recalls it happening to other children living at Cullen.

84. Indeed, on at least three occasions, JOHN DOE (VC) 1 saw other guards sexually assault, and even rape, other young boys, particularly in the showers, where some guards would hold down the young boys while another male anally raped a child.

85. As a direct and proximate result of the counselor's abuse, JOHN DOE (VC) 1 suffers from severe depression and post-traumatic stress disorder, flashbacks, night tremors and has trouble maintaining relationships and controlling his anger. He is currently disabled as a result of losing three fingers in an accident after becoming so irate about the events at Cullen and the impact it has had on his life.

ABUSE OF JOHN DOE (VC) 2

86. Plaintiff JOHN DOE (VC) 2 was 16 years old when his abuse and harassment began by a female officer. JOHN DOE (VC) 2 recalls the officer taking him to the administration building approximately 10 times during 1998 and the officer forcing JOHN DOE (VC) 2 to remove his pants and underwear and sit in a chair. The officer then mounted JOHN DOE (VC) 2 and forced him to penetrate her vagina, even once breaking the arms off of the chair while she engaged in sexual intercourse with the Plaintiff.

87. The officer told him that he repulsed her and threatened the 16-year-old against reporting her abuse to anyone.

ABUSE OF JOHN DOE (VC) 3

88. Plaintiff JOHN DOE (VC) 3 was also 16 years old when his abuse began at the hands of another female counselor. During JOHN DOE (VC) 3's stay at the facility, the officer

would wait until the young boy was alone and then she would approach him, touching and rubbing against him in private areas. Eventually, his abuser became more brazen in her harassment of JOHN DOE (VC) 3, and she began performing oral sex on him and forcing him to penetrate her. This would often happen in the evening and at night and became a regular occurrence. JOHN DOE (VC) 3 estimates this happened on at least 15 occasions.

89. Once, the officer was caught having sex with JOHN DOE (VC) 3 by several other students at Cullen who walked in on the couple. Following that incident, the counselor left the facility and never returned to work. JOHN DOE (VC) 3 was reassigned to the Superintendent, who had no other children assigned to him in any counseling role. As a consequence of the relationship with the counselor, the Superintendent demoted JOHN DOE (VC) 3 to a lower-level housing unit, taking away his right to wear sneakers and effectively lengthening the time remaining to serve in his program. Then, unexpectedly one day and against Cullen rules, JOHN DOE (VC) 3 was suddenly released from the facility and allowed to return to his home. Between the time of being caught and the time of his leaving Cullen, both the residents and other counselors at Cullen would openly talk about the incident where the counselor had been caught having sex with the young man.

ABUSE OF JOHN DOE (VC) 4

90. Plaintiff JOHN DOE (VC) 4 was 15 years old when he was abused and harassed by two different officers while a resident of the facility in 1994.

91. The first officer once escorted JOHN DOE (VC) 4 to the medical unit and on her way, she asked him if he knew how to kiss and if he wanted to kiss. When he said no, she stopped their walk and kissed him anyway, taking her hands and grabbing his penis under his pants in order

to fondle him. On the next occasion, she repeated the acts but this time forced the child to have sexual intercourse with her in a private area.

92. On another occasion, after being injured, a male officer escorted JOHN DOE (VC) 4 to the medical unit and likewise fondled JOHN DOE (VC) 4's penis. On other occasions, the second officer would forcefully penetrate the young boy's anus while in medical transit or in the gym alone.

ABUSE OF JOHN DOE (VC) 5

93. While a resident of Cullen, Plaintiff JOHN DOE (VC) 5 was abused by a counselor on at least three occasions, while the boy was 15 years of age. The counselor would instruct the boy to go into the staff restroom and then she would follow him, pull down his pants and perform oral sex on him and then engage in vaginal intercourse with the boy. To ensure the boy would not report her, the counselor would bring him food from outside the facility and also bring him condoms to use when they had sex.

ABUSE OF JOHN DOE (VC) 6

94. Plaintiff JOHN DOE (VC) 6 was similarly preyed upon by a female counselor on at least 5 occasions while he was 15 to 16 years old. The abuse normally happened in her office, although on one occasion, JOHN DOE (VC) 6 recalls that the counselor walked him around the side of the building where no one could see the two. There, she proceeded to perform oral sex on the boy. It was also not uncommon for the counselor to have three other boys with her at the time, who were instructed to maintain an outlook while she had sex with the plaintiff. Occasionally, she would do the same with the other young men.

95. At times when she was not pursuing sex from him, she would fondle the JOHN DOE (VC) 6's penis wherever she could - on the bus, in her office or in the back hallway of Cullen.

96. As a direct and proximate result of the sexual abuse of JOHN DOE (VC) 6, he has been diagnosed with anxiety and depression and is on medications to treat his symptoms.

ABUSE OF JOHN DOE (VC) 7

97. Plaintiff JOHN DOE (VC) 7 was only 12 years old when his abuser began his torment. He had been confined at Cullen because he was attempting to escape an abusive situation. Instead of saving him from his prior abuser, DJS placed him at Cullen, where he was met with even more systematic abuse. There, his predator, an officer and unit supervisor would approach the young boy while he was in his dorm room. The officer told the boy that he would beat JOHN DOE (VC) 7 physically or have another group of boys do his bidding if the child did not do as he was told. The officer then proceeded to masturbate the boy and to demand that the boy perform oral sex on the officer. Each time that the boy initially refused, the officer threatened him with having other juveniles attack him.

98. As a direct and proximate result of his abuse, JOHN DOE (VC) 7 suffers from substance abuse, severe anxiety, depression and PTSD, with flashbacks, suicidal ideation, and attempted to hang himself while later incarcerated.

ABUSE OF JOHN DOE (VC) 8

99. Plaintiff JOHN DOE (VC) 8 was 15 when another guard began to fondle him. This would sometimes happen in the "dayroom," which is where the residents could watch television. On several occasions, JOHN DOE (VC) 8 was the last child to leave the room and the guard [Smitty] would ask him to help organize the chairs. As the boy proceeded to do that, the guard would begin to fondle the boy's penis under his clothes. The guard threatened the boy with a "write up" which would prevent JOHN DOE (VC) 8 from returning to his home.

RESPONDEAT SUPERIOR

100. 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

101. While Maryland has partially waived immunity under the Maryland Tort Claims Act as amended by the Child Victims Act, and Md. Ann. Code, State. Gov't., § 12-104(a), to the extent claims herein trigger any governmental immunities, damages are sought only under and up to the amount of insurance coverage available.

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

COUNT I: NEGLIGENCE

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

104. At relevant times, Defendant was required to appropriately manage, supervise, and treat youth involved in the juvenile justice system in Maryland. 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.

105. 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.

106. These duties and obligations are statutorily mandated and are non-delegable. Even though Defendant has, through the years, contracted with third party providers (such as YSI and

Rebound) as agents for some of these services, the ultimate responsibility for oversight, management and operations at all levels of the Victor Cullen Center remains with DJS, as assigned by the Legislature.

107. These duties and obligations require Defendant to meet applicable standards of care for facilities such as the Cullen Center under its operation and control.

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

109. 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 abuse;

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

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

111. To the extent that DJS selected and contracted with third-party providers, Defendant was negligent in selecting and contracting with said entities, whom it failed to properly vet to ensure suitability for the critical services to be provided.

112. The exact services third parties were contracted to provide, if they did so at Cullen, are currently unknown to Plaintiffs, who lack access to those contracts, but upon information and belief, such services would have included direct supervision, personal protection and care of youth at Defendant's facilities including but not limited to the Victor Cullen Center.

113. These third-party providers breached the national standards of care applicable to their services to youth, more specifically by hiring, failing to supervise, and continuously retaining unfit staff who perpetrated upon youth as set forth with specificity above.

114. The acts and omissions of any third-party providers, as well as individual perpetrators are imputable to DJS as principal/employer and holder of these non-delegable duties.

115. The acts and omissions of any third-party providers selected and paid by Defendant are imputable to Defendant as principal/employer and holder of these non-delegable duties.

116. 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/or 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 II: NEGLIGENT HIRING, SUPERVISION, AND RETENTION

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

118. 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 the Victor Cullen Center. Md. Code, Hum. Servs. § 9-201 et seq.

119. Defendant directly hired individuals at executive levels to oversee, manage and operate juvenile justice facilities including the Victor Cullen Center.

120. In addition, Defendant selected and hired both direct employees and third-party agents and providers (such as YSI and/or possibly others) to oversee, manage, and operate the Victor Cullen Center.

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

122. 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 the Victor Cullen Center and other facilities under its control.

123. Defendant breached this duty and others by hiring, either directly or through third-party providers, not only unqualified and incompetent executives, providers and staff, but in some

cases dangerous individuals with known criminal backgrounds and/or readily ascertainable histories of abusing youth in other facilities.

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

125. Defendant would have known of these providers' and 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 in their care, including Plaintiffs.

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

127. Defendant breached this duty by failing to monitor and supervise their direct staff and the performance of third-party providers and their staff to ensure that sexual abuse was not occurring.

128. Defendant and/or its selected third-party providers breached this duty by failing to investigate complaints both by youth residents and by independent evaluators that staff and youth at the Victor Cullen Center and other facilities under their control were perpetrating sexual abuse upon residents, including Plaintiffs.

129. Defendant and its selected third-party providers each 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.

130. Defendant and/or its selected third-party providers breached this duty by continuously retaining both its direct staff members and third-party providers' staff members

whom they knew or should have known had dangerous propensities and/or had sexually abused youth.

131. Each of these breaches violated Defendant's statutorily mandated duties and applicable standards of care, as well as standards of care applicable to third-party providers.

132. Defendant had the power to terminate its direct employees and, at minimum, power to terminate its contract with any third-party provider who failed to protect youth from sexual abuse.

133. Defendant failed to exercise this power and was negligent in both the supervision and retention of its direct employees and those of the third-party providers with whom it contracted.

134. Defendant failed to promptly terminate the contracts with third-party providers despite actual or constructive knowledge of the sexual abuse the providers' staff were perpetrating upon youth, including Plaintiffs.

135. 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.

136. Had Defendant's selected third-party providers 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.

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

138. 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/or 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 III: NEGLIGENT FAILURE TO TRAIN AND EDUCATE

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

140. 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.

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

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

143. 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.

144. While Defendant was permitted to hire third- party providers to carry out its work, Defendant retained at all times a duty to ensure that the staff of third- party providers were properly trained in regard to protecting children from sexual abuse.

145. Because these duties originate by statute and at the direction of the Maryland Legislature, Defendant cannot fully abdicate the ultimate responsibility to protect minors in its care, even when it hires third -party providers.

146. Defendant or others acting on its behalf or under its direction or control (both direct and third-party providers), 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 its staff, employees, and/or agents (direct and third parties) on behaviors constituting sexual abuse by staff and/or among residents;

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

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

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

g. Failing to properly train or educate its staff, employees, or 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.

147. 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.

148. 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/or disfigurement, past and continuing into the future;

b. Severe emotional distress, including pain and suffering, 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: GROSS NEGLIGENCE

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

150. 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. This was equally true in regard to direct hires and anyone employed by third party providers.

151. In turn, all third-party providers had a duty to hire and retain only qualified staff to serve youth in Defendant's facilities.

152. Defendant and its selected third-party providers, separately and jointly, intentionally failed to act on literally decades of complaints and allegations both from youth residents and independent evaluators which informed them that numerous staff had, and were continuing to, perpetrate sexual abuse upon the youth in their care.

153. 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.

154. As such, Defendant and its selected third-party providers, or one or more of them, were grossly negligent in failing to perform their statutorily mandated, nondelegable and assumed duties to protect Plaintiffs and other youth from sexual abuse.

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

156. 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/or disfigurement, past and continuing into the future;

b. Extreme 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. R. Civ. Pro. Cir. Ct. 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 V: PREMISES LIABILITY

157. Plaintiffs incorporate and reallege all paragraphs of this Complaint into this Count.

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

159. Defendant owed Plaintiffs a duty to use reasonable care under all circumstances in the maintenance and operation of the premises, and to take reasonable precautions to protect Plaintiffs against foreseeable dangers arising out of the arrangements or use of the premises.

160. Defendant knew or should have known of the risk that its staff, employees, and/or agents (either its direct hires, or those of its selected third-party providers) 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.

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

162. 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.

163. 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 its staff, employees, and/or agents (direct and those of its selected third-party providers) and/or residents who perpetrated sexual abuse upon Plaintiffs.

164. 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 (and others staffed by its selected third- party providers) prior to the actual sexual abuse of Plaintiffs, all of which made imminent harm foreseeable.

165. 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 and harassment;

b. Improperly protecting Plaintiffs, then minors, from sexual abuse and harassment;

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

d. Ignoring and/or otherwise failing to properly address complaints about numerous instances of sexual assaults occurring in Cullen;

e. Failing to promptly report Plaintiffs' sexual assaults to the authorities;

f. Failing to take any action to prevent retaliation against Plaintiffs after their assaults were reported to Cullen;

g. Failing to conduct an exit interview with Plaintiffs when they left Cullen;

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

i. Retaliating against Plaintiffs for reporting that they were sexually assaulted by subjecting them to arbitrary, capricious, and unwarranted "discipline" for pretextual reasons that masked the discriminatory nature of the facilities' treatment of them; and

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

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

167. Defendant's conduct was wanton, malicious, or oppressive, or Defendant disregarded or exhibited reckless indifference to the foreseeable risks of harm and acted with ill will, hatred, hostility, a bad motive, or the intent to abuse its power.

168. 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/or 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 VI: ARTICLE 24 MARYLAND DECLARATION OF RIGHTS – SUBSTANTIVE DUE PROCESS

169. The proceeding paragraphs are incorporated as though fully set forth herein.

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

171. The Maryland Constitution and principles of *respondeat superior* require the Defendant to avoid Constitutional violations by its employees, staff and agents through adequate training and supervision and by disciplining employees, staff and agents for unlawful conduct.

172. 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 the Cullen Center.

173. All the perpetrators' actions occurred within the course of their duty and within the scope of their employment at the Cullen Center.

174. Plaintiffs have a substantive due process right to bodily autonomy.

175. The perpetrators repeatedly acted deliberately and with intent to violate Plaintiffs' rights under Article 24.

176. Defendant is vicariously liable for the perpetrators' violations of Plaintiffs' rights under Article 24.

177. Defendant therefore deprived Plaintiffs of their right to bodily autonomy under Article 24 when the perpetrators repeatedly sexually abused Plaintiffs.

178. As a direct and proximate cause of Defendant's unconstitutional conduct, Plaintiffs were deprived of their substantive due process right to bodily autonomy.

179. 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)

180. The proceeding paragraphs are incorporated as though fully set forth herein.

181. It is the custom and practice of the Defendant to permit its employees, staff, and/or agents to violate children's substantive due process rights to bodily integrity by physically and sexually abusing them.

182. Defendant failed to properly train and supervise Cullen Center employees, staff, and/or agents to prevent those repeated Constitutional violations.

183. Defendant's failure to properly train and supervise its Cullen Center employees, staff, and/or agents demonstrated gross disregard for Plaintiffs' Constitutional rights.

184. Defendant's failure to train and supervise Cullen Center employees, staff, and/or agents is patently obvious from the repeated sexual abuse that Plaintiffs and other children at Cullen Center have experienced for decades.

185. As a result of the failure to train and supervise, and the permitted pattern of practice at Cullen Center, Defendant's employees, staff, and/or agents were allowed to sexually assault children.

186. Defendant's Cullen Center employees, staff, and/or agents failed to report these incidents of reckless and intentional unlawful conduct, and Defendant lacked effective procedures to control or monitor its Cullen Center employees, staff, and/or agents who had a pattern or history of unlawful behavior.

187. Defendant caused its Cullen Center employees, staff, and/or agents to believe that unlawful sexual abuse would not be aggressively, honestly, and properly investigated.

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

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

190. 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.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray unto the Court:

1. Enter judgment against Defendant in favor of the Plaintiffs for a sum in excess of $30,000, jointly and severally;
2. For a trial by jury on all issues so triable;
3. That the costs, including expert witness fees, of this action be taxed against Defendant;

4. Pre-judgment interest and post-judgment interest;

5. For reasonable attorneys' fees as allowed by law; and

6. For such other and further relief as the Court deems just and proper.

This the 1st day of October, 2023.

Respectfully submitted,

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**Pro hac vice forthcoming*
Attorneys for Plaintiffs

IN THE CIRCUIT COURT FOR ANNE ARUNDEL COUNTY, MARYLAND

JOHN/JANE DOES (WC) 1-10, inclusive,	:	
Plaintiffs,	:	
v.	:	
The STATE OF MARYLAND, acting through its agencies, MARYLAND DEPARTMENT OF JUVENILE SERVICES, and/or DEPARTMENT OF HEALTH (formerly the DEPARTMENT OF HEALTH AND MENTAL HYGIENE)	:	Civil Case No.:
	:	Filed:
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."

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

INTRODUCTION

The Thomas J.S. Waxter Children's Center was founded 60 years ago with a mission to reform, repair, and re-socialize troubled youth. Instead, decade after decade, the Waxter Children's Center has been the site of rampant, documented sexual abuse, harassment, coercion, and manipulation such that many of the girls and boys committed to its care were released more badly damaged than when they arrived. Damaged, in fact, for life.

Waxter housed children from troubled backgrounds. Most children were minorities, almost all came from poverty, and most had histories that demanded trauma-informed care – not the infliction of additional trauma. Some of the young people sent to Waxter Children's Center had committed felonies. Some had committed misdemeanors. Some were sent after violating probation by breaking curfew or skipping school. Some of the children were awaiting adjudication. Some were there for mental health or substance abuse treatment. Some were abused, heartbreakingly, while being housed between foster homes; they had committed no crimes at all.

At some point during their childhood, each of the Plaintiffs was housed at Waxter Children's Center for a period of days, weeks, or months, during which time each child was under the direct custody, care, control, and direction of the State of Maryland through its agencies, currently the Department of Juvenile Services. During each Plaintiff's time at Waxter, the State of Maryland's employees, agents, and third-party contractors used their positions of trust and authority to sexually abuse Plaintiffs. Plaintiffs were forced to remove their clothes while guards molested them, sometimes holding them down to do so. As young as nine years old, they were forced to perform oral sex, be penetrated vaginally and anally with fingers and objects, and raped.

The culture of abuse permeated Waxter's campus. Children were abused in bathrooms, showers, utility closets, and even in their own bedrooms with doors locked from the outside. Sometimes, the children were bribed with food and privileges; others, the children were threatened

or beaten; still others, the children were simply held down on the ground as their abusers used force to take what they wanted.

The culture of silence at Waxter made it impossible for the children to report their abuse. Many children were told they or their families would be killed if they reported what happened. The amount of violence and crime at Waxter made these threats very real to the children: guards set up fight clubs where children would fight for entertainment and status; guards held themselves out as street thugs and drug dealers; guards beat children as retaliation for not being able to receive anal sex. Boys and girls who knew about the Waxter grievance system found that they were reporting to the peers of their abusers; their complaints were rebuffed and ignored. A culture of silence prevailed, with staff mocking their young charges with a familiar refrain: "Who's going to believe YOU?"

The girls and boys at Waxter were subjected to these violations in a chaotic, dangerous, and toxic environment, including the unchecked use of restraints, seclusion, and humiliation as punishment and the withholding of desperately needed mental health and medical care. An OB/GYN who treated Waxter's girls was kept on staff despite repeated reports of inappropriate conduct. Youth were strip searched after visits with family members, meetings with lawyers, medical appointments, court appearances and off-campus excursions, even when the excursions were rewards for good behavior. While suicidal ideation and behavior was rampant at Waxter, youth experiencing these catastrophic mental health crises were forced to strip naked and stand in their cells, often without access to so much a mattress, while guards looked on or used their humiliation as an opportunity to sexually molest and abuse them further. In 2011, a juvenile justice monitoring report summed up the situation at the facility neatly: "The Waxter detention facility should be closed." It was – 11 years later.

Plaintiffs file this Complaint to seek justice for the innumerable instances of child sexualization, humiliation, degradation, harassment, sexual abuse, and other illegal treatment inflicted upon Plaintiffs and others who endured similar abuse; to recover damages for the abundant and lasting scars – physical and mental – the Plaintiffs have been left with; to punish the perpetrators and to make sure this sort of abuse is never allowed again under the State of Maryland's watch.

THE PARTIES PLAINTIFF

1. Plaintiffs are former residents or detainees of the Waxter Children's Center in Maryland.

2. Their abuse occurred between 1978 and 2006 when Plaintiffs were minor children, generally 11 to 19 years old, with one boy aged 9 at the time of his abuse.

3. Plaintiffs' current ages range from 43 to 55 years old.

4. Plaintiffs John/Jane Does (WC) 1-10 are now adult residents and citizens of various states, who resided at the Thomas J.S. Waxter Children's Center, Anne Arundel County, Maryland at relevant times herein.

5. Plaintiffs bring their claims pursuant to the Child Victims Act of 2023, which recognizes that the soul-crushing and sometimes physically debilitating legacy of childhood sexual abuse lasts a lifetime.

6. Plaintiffs John/Jane Does (WC) 1-10 file this Complaint under the pseudonyms of John/Jane Does (WC) 1-10 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.

7. Plaintiffs are all persons who as minors were housed, detained or incarcerated within juvenile justice facilities at the times of the acts complained of herein. Court records pertaining to children are protected as confidential pursuant to Md. Code, Cts. & Jud. Proc. § 3-8A-27 (2002) which 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 breach that confidentiality.

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

9. Further, publication of the intimate and private material in this case involves the risk of 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, due to the publication of the intimate material. If Plaintiffs are not allowed to proceed under pseudonyms, certain of them will experience further harm as a result of exercising their legal rights. 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.at issue here.

10. 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.

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

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

THE DEFENDANT AND ITS AGENCIES

13. Defendant, the State of Maryland ("the State" or "Defendant"), enforces Maryland's laws through its Executive Branch, consisting of various officers and agencies as authorized by Maryland's Constitution and its laws. 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.

14. From 1969 to 1987, the Juvenile Services Agency within the Department of Health and Mental Hygiene ("DHMH") was responsible for the management, supervision and treatment of youth who were involved in the juvenile justice system. DHMH was renamed the Department of Health in 2017.

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

16. In 1989, the State General Assembly established the Department of Juvenile Services ("DJS") to assume 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." In 2003, the General Assembly reverted DJS back to its original name.

17. 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.

18. DJS currently oversees six juvenile detention centers, and four committed placement centers (one closed indefinitely).

19. DJS or its predecessors have operated additional juvenile detention and committed placement centers that are now closed, including, but not limited to, the Montrose School closed in 1988, and the Thomas J.S. Waxter Children's Center closed in 2022.

JURISDICTION AND VENUE

20. 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 above. Each of those agencies conducts or conducted business in Anne Arundel County, Maryland during the relevant period.

21. Venue in this Court is proper under Md. Code, Cts. & Jud. Proc. § 6-201, because Defendant "carr[ies] on a regular business" in this County.

22. Jurisdiction and venue are proper 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 Anne Arundel County.

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

24. 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).

25. 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).

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

THE DUTIES OF THE DEPARTMENT OF JUVENILE SERVICES

27. DJS holds itself out as "a child-serving agency responsible for assessing the individual needs of referred youth and providing intake, detention, probation, commitment, and after-care services." According to its website, the Vision of the Department is, "Successful Youth, Strong Leaders, Safer Communities." The Goals of the Department are to "[i]mprove positive outcomes for justice-involved youth, to only use incarceration when necessary for public safety, to keep committed and detained youth safe while delivering services to meet youth needs, to ensure a continuum of care for justice-involved youth that is age- and developmentally-appropriate, to build, value, and retain a diverse, competent, and professional workforce and to enhance the quality, availability, and use of technology to improve services for staff, youth, and families."

28. 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.

29. DJS is also the administrative agency of the State charged with setting standards for juvenile detention facilities that are operated both by DJS and by private third-party providers. Md. Code, Hum. Servs. § 9-237. The standards reflect adherence to three critically important central purposes of juvenile detention. These being 1.) to protect the public; 2.) to provide a safe, humane, and caring environment for children; and 3.) to provide access to required services for children. *Id.*, at (b)(1)-(3).

30. Among the specific standards, there are provisions that seek to eliminate the unnecessary use of detention, establish population limits for juvenile detention facilities; set staffing ratios; provide for staff qualifications and training to recognize and report child abuse and neglect; protect a juvenile's right to privacy; prohibit excessive force against a child; and impose auditing and monitoring of programs and facilities. *Id*., at (c)(1)-(12).

31. DJS is 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 residential program to provide "a safe, humane, and caring environment."

32. 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,"90 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.

33. 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."

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

35. Despite its obligations, and in violation of state law and its own regulations, DJS knew of the incidents, reports, and culture of abuse at the Waxter Children's Center during its

years of operation but failed to meet the minimum conditions required for its facilities by the U.S. and Maryland Constitutions and its own authorizing statutes.

36. The failure to address and remediate the harms identified in the myriad internal and external investigations into the abuse and neglect of children at the Waxter Children's Center and other facilities directly enabled the sexual abuse of the Plaintiffs.

THE STATE'S COMMITMENT TO THE PREVENTION OF CHILD ABUSE – INCLUDING SEXUAL ABUSE

37. 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.

38. The Maryland Constitution provides similar protections to individuals in State custody, including juveniles.

39. In addition to the federal and state Constitutions, there can be no question that one of our state's greatest moral obligations is to the prevention of child abuse and the protection of children from all forms of abuse, but particularly sexual abuse. This is why Maryland mandates that anyone who suspects abuse or neglect has an obligation to report that suspicion and provides immunity to them for acting in good faith with that obligation. See Md. Code, Fam. Law § 5-702. In addition, like many states, Maryland specifies that certain professionals and workers must report whenever they have a reason to believe that a child has been subjected to abuse or neglect. *Id*., at 5-704(a).

40. Staff members in a juvenile detention center are expressly among those positions that must report such abuse to the head of their institutions, being required to make both an oral report as well as a written report to their appropriate department and law enforcement agencies and officers. *Id*.

41. Over the last several decades, amid repeated reports of abuse at several detention centers, the State has conducted numerous investigations into DJS operations.

42. In the 2000s, following a series in the Baltimore Sun, a Juvenile Justice Monitoring Unit ("JJMU") was established within the Office of the Maryland Attorney General. From 2010 to the present day the JJMU has issued quarterly and annual reports on incidents within Maryland's juvenile detention facilities.

43. These quarterly reports do not specifically categorize incidents of staff-on-youth physical or sexual abuse.

44. However, the reports have documented a troubling volume of problems such as the excessive use of restraints on children, strip searches, programmatic failures, and incidents of suicide ideation, gestures, attempts or behavior throughout Maryland's juvenile detention facilities, including the Waxter Children's Center.

THE CULTURE OF ABUSE AND NEGLECT AT WAXTER

45. The Thomas S.J. Waxter Children's Center was opened in the early 1960s and later renamed in honor of Thomas S. J. Waxter, the longtime director of the State Department of Public Welfare. Originally designed for both boys and girls, it became a center only for girls in 2000 and until November 2011 was Maryland's only secure commitment facility for girls.

46. The Waxter Children's Center was shuttered by the state in January 2022 – but its legacy of abuse and neglect lives on.

47. In 1967, the U.S. Department of Health, Education and Welfare investigated the Maryland juvenile detention system, finding it "too large" and marked by "an overuse of institutionalization," leading to the first of what would be many recommendations for Maryland

to establish community-based programs for delinquent youth capable of being treated in the community.

48. Within the juvenile detention system, Waxter Children's Center was a smaller facility, with fewer than 50 beds. But even as a small facility, Waxter, under management of the State of Maryland, routinely failed its young charges.

49. Victims housed at Waxter as children describe a culture of verbal and physical abuse that enabled the sexual abuse to occur unabated.

50. The staff at Waxter would conduct "fight clubs" where children would fight each other as entertainment for the staff and other children. Staff would smuggle in prohibited outside food, like McDonald's, for the victors, and give them privileges around the facility. Those who won at fight club were expected to discipline other children by beating them. Those who lost at fight club were beaten, harassed, and had their food withheld.

51. The Waxter staff was assailed in one JJMU report for the excessive use of restraints on children housed there – finding that restraints were used on children housed at Waxter an average of 4 to 12 times during their stays at the facility.

52. One form of seclusion used as punishment was "cell lock." Children placed on cell lock had to stand in their cells, nude, for long periods of time. Guards and other children would walk by, look at them, and laugh. Children subjected to this practice have described it as like being a zoo animal – deprived of clothing and put on display for all to see.

53. One of the most common reasons for the use of the "cell lock" procedure was that a child was experiencing suicidal ideation, had engaged in self-harm, or had attempted suicide. Cell lock was used, often in lieu of mental health treatment, to make children who were already incredibly distressed even more vulnerable.

54. In 2006, Katherine Perez, Maryland's independent monitor of juvenile prisons, visited Waxter with a colleague. Even in front of the independent monitor's team, abuse occurred. Perez and her colleague witnessed a male guard pull a girl resident into a room after she said something he did not like. They heard her yelling at him to stay off of her and they watched through a window as he punched her, while one of his colleagues tried to deflect the situation.

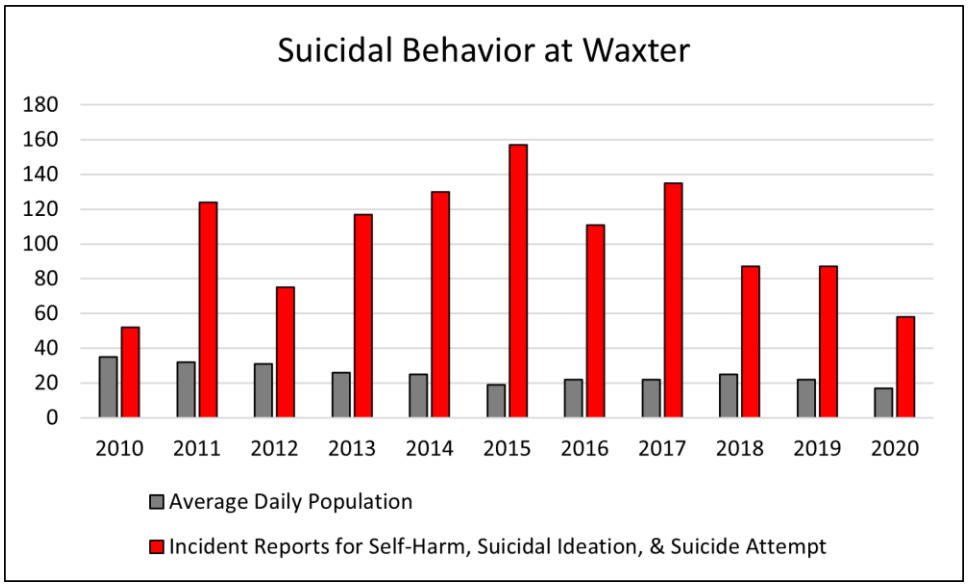
55. Nothing, however, illustrates the hopelessness of the children at Waxter more clearly than the numbers of young detainees who engaged in suicidal ideation and behaviors.

56. In 1994, a 12-year-old boy housed at Waxter died, allegedly by hanging. The boy was confined to his room due to disciplinary problems. On the day of his death, he was frequently heard kicking and screaming; his body was found after other students reported he had gone quiet. The state medical examiner ruled it a suicide. The mother stated that a Waxter employee told her the boy was found with a sheet next to him, not around his neck, and his clothing contained evidence of assault.

57. Seven years after the 12-year-old boy was found dead, the Office of the Independent Monitor listed among its major findings that Waxter lacked a suicide prevention plan.

58. That was February 2001. In March 2002, a 15-year-old girl in state custody for petty property crimes was found hanging by her shoelaces from a bottom bunk.

59. The JJMU monitoring reports, available on the Maryland Attorney General's website, reveal a pattern of incident reports for self-harm, suicidal ideation, and suicide attempts from 2010 to 2020 that is both startlingly high and consistent.



60. Until 2011, Waxter was supposed to be a secure treatment facility for girls. However even basic medical care was perilous for the girls at Waxter.

61. One of the treating caregivers was a physician who provided OB/GYN services to the female teenagers at Waxter – a physician the JJMU found to have violated DJS standards of appropriate conduct.

62. That physician, whom many girls at Waxter refused to see because of the inappropriate conduct, was kept on staff even after the JJMU brought it to light. Girls who refused to be examined by this individual were not provided with alternative services to meet their medical needs.

63. The pattern of failing to meet basic needs continued throughout the 2010s. Throughout the decade, the JJMU described conditions at Waxter as "dilapidated," "decrepit," "in a state of disrepair," and "in need of extensive renovation for the facility to be habitable." Faulty heating and cooling systems subjected the girls to extreme heat in the summers and freezing temperatures in the winters. Condensation coating the walls and floors turned to mold and mildew, and girls routinely complained of the smell and developed respiratory issues. The walls and doors

leaked, the floors had holes, the showers were constantly broken, there was no hot water, the facilities were infested with rats and bugs, and the smell of raw sewage permeated the air.

64. These issues not only presented squalid living conditions for the girls; they also made it impossible for the facility to retain staff.

65. The JJMU reported that the terrible facility conditions stopped the facility from recruiting qualified personnel to supervise the girls and administer the program. Indeed, throughout the years, the JJMU noted that Waxter continually struggled to find qualified employees willing to work there, and that job vacancies were frequent and hard to fill.

66. Waxter's staffing issues contributed to the persistent mistreatment of children housed there.

67. For example, in 2011, the JJMU found that, due to a lack of staff to escort them to Waxter's classrooms, many girls - especially those with physical and mental disabilities - were being left in their cells instead of receiving education services.

68. The lack of staff and poor training were inadequate to the task at hand for the Waxter population.

69. By 2017, the data showed that 81% of the girls in Maryland's juvenile justice system had moderate-to-high mental health needs, yet the JJMU documented and substantiated multiple instances where Waxter used physical restraint in lieu of de-escalation and mental health treatment because mental health staff were unavailable. For example, when a youth who had thrown juice and cards did not want to be touched, Waxter staff backed her up to a wall and carried her to her cell by her arms and legs. When a different youth asked to speak with a case manager or mental health counselor because the phone system did not work correctly and shut off unexpectedly, Waxter refused to contact the on-call therapist, and instead told the girl to go to her

cell. When she would not, and instead began walking on chairs and tables and pulling ceiling tiles, she was physically restrained and carried to her cell by her arms and legs.

70. The policies at Waxter also encouraged the unnecessary strip searches of youth even though JJMU consistently recommended that all Maryland DJS facilities completely cease the practice, due in part to research showing that strip searches have a more serious impact on children than adults and can seriously traumatize children. All youth at DJS facilities including Waxter were required to be strip searched after all visits with family members, visits with lawyers, off-grounds travel, medical appointments, school appointments, court hearings, and outings earned as rewards. In one striking example at an unidentified facility in 2015, all youth in the facility were strip searched after a staff member misplaced their keys – even though the keys had been returned to the master control area by another staff member.

HOW ABUSERS SILENCED VICTIMS

71. The abusers on staff at Waxter took affirmative steps to avoid detection and reporting.

72. For example, the adults running the fight club would stop the fights before anyone got so injured that they could not survive without medical care, because if someone needed the infirmary, an incident report would be written.

73. Because offering abuse victims medical treatment would result in the abuse being documented in writing and potentially revealed, abuse victims at Waxter were routinely denied medical care.

74. It was an open secret at Waxter that staff would use normal chores as opportunities to isolate children for abuse.

75. For example, one child at a time would be assigned to clean the bathrooms. That child would be alone with a staff member, away from cameras and other children, for a long time. Alone with staff in the bathroom, children would frequently be subjected to sexual abuse.

76. Reporting of abuse was fruitless, the victims found. Those who tried to file "grievance reports" discovered that they were supposed to report to their abuser or his or her friends on staff. Victims were told the facility was out of forms, out of paper. Worse yet, victims were promised that things would change; they never did.

77. The abusive staff made repeated and direct threats to their victims, suggesting that the abusers would retaliate if the children reported what happened to them.

78. Some threats were general, such as one guard who told her victims to keep their mouths shut if they knew what was best for them; others, such as a guard's threat to kill his victim's family, were frighteningly specific.

79. Staff threatened to physically harm children, withhold their food, falsify behavioral reports about the children, and extend children's sentences if they reported what the abusers did.

80. Children feared retaliation by abusers so much that some of them would not speak about what happened, even to their peers. When children did discuss the abuse with their peers, they would have to huddle together quietly for fear of being overheard and punished.

81. Humiliating and traumatizing procedures like "cell lock" and strip searches were used both as punishments and as opportunities for more abuse to occur.

82. The "cell lock" procedure gave Waxter's staff easy access to nude children, and the staff frequently used this access to sexually harass and molest the children.

83. Restraint and seclusion, including “cell lock,” were among the many consequences Waxter’s personnel threatened or used any children who reported their abuse.

84. Strip searches were often done at the whim of staff members, and often preceded instances of molestation or rape.

85. Staff also helped avoid the reporting of sexual abuse by targeting child victims with the weakest support systems. Guards observed who received visitors frequently and who did not, and those with the fewest visitors became the biggest targets for abuse.

86. Guards would also work to isolate their victims from any support the victims had. One victim reported signing up for telephone privileges regularly but never finding his name on the docket.

87. Children were constantly reminded by their abusers that the children were offenders, the children were criminals, and that the children would never be believed, while the guards who molested, raped, and abused them were upstanding members of the community who would always be believed over the children. They were constantly asked, “Who would ever believe someone like you over me?” by the people molesting them.

88. Despite the staff's consistent efforts to avoid reporting, when abuse was reported, nothing happened.

89. Even with case workers or probation officers brought forward reports, Waxter made zero effort to remove abusers from positions where they were in contact with children.

90. When the children would trade experiences at the facility, they would learn how hopeless Waxter’s reporting and grievance process really was. At least one victim chose not to report because his abuser had already been reported before, without any reprimand or discipline to the abuser.

91. Any child who reported abuse was regarded as a snitch and subject to a campaign of harassment and torture by the staff and other students.

92. Children who came forward about their abuse were beaten, denied food, denied recreation time, and smacked in the mouth for speaking out.

93. The fear of retaliation this abuse and harassment caused in the children frequently stopped them from reporting abuse, even when they wanted to.

94. Some victims report that they would have preferred being tried as adults, because adult prison conditions were so much better and involved so much less sexual abuse.

DEFENDANT'S ABUSE OF THE PLAINTIFFS

THE ABUSE OF JOHN DOE (WC) 1

95. JOHN DOE (WC) 1 was eleven years old when a male employee began sexually abusing and harassing him. Upon information and belief, the employee was a guard at the facility.

96. The abuse, which occurred on at least forty occasions, began in approximately 1986.

97. Among other things, JOHN DOE (WC) 1 was forced to perform oral sex on the officer approximately seven times in JOHN DOE (WC) 1's room, in the bathroom, and elsewhere. JOHN DOE 1 (WC) was forced to endure oral sex by this employee approximately fifteen times. The officer forced JOHN DOE (WC) 1 to masturbate the employee to the point of ejaculation, bare handed. This occurred in the shower, back dorm room, activity area, bathroom, and JOHN DOE (WC) 1's room. It occurred most commonly when JOHN DOE (WC) 1 was forced to clean the bathrooms while his peers went to exercise.

98. JOHN DOE (WC) 1 was forced to endure masturbation by the guard to the point of ejaculation about seven times.

99. The officer forcefully tried to sodomize/penetrate JOHN DOE (WC) 1 with his fingers on three occasions, and he was only unable to do so because JOHN DOE (WC) 1 was in too much pain. On one occasion when this happened, the guard became so angry at JOHN DOE (WC) 1 that he punched the child in the face.

100. The guard intimidated JOHN DOE (WC) 1 into silence by telling JOHN DOE (WC) 1 that no one would believe him, and by suggesting the employee would have JOHN DOE (WC) 1's entire family killed if JOHN DOE (WC) 1 spoke up about the abuse.

101. Among other damages, JOHN DOE (WC) 1 has dealt with depression, suicidal ideation, and post-traumatic stress disorder for decades as a result of the abuse.

THE ABUSE OF JANE DOE (WC) 2

102. JANE DOE (WC) 2 was twelve years old when a male employee began sexually abusing and harassing her. Upon information and belief, this employee was a guard, officer, supervisor, watchman or some other type of staff member at the facility.

103. The abuse, which occurred on at least three occasions, began in approximately 1990.

104. The abuse started with verbal harassment, where the employee would comment on JANE DOE (WC) 2's appearance and body. For example, when the child became re-incarcerated at Waxter after being released, the employee would say, "the hot ass is back."

105. Among other things, the employee would use his key to enter JANE DOE (WC) 2's cell at night to molest and rape her. He groped JANE DOE (WC) 2 's vagina underneath her underwear, bare handed. He penetrated JANE DOE (WC) 2 's vagina with his fingers and then proceeded to rape her. He also forced her to perform oral sex on him.

106. The employee abused JANE DOE (WC) 2 in a similar manner on several other occasions.

107. The employee was very open about getting high and using drugs on the job. He would bring drugs to work and distribute them to the children, often as a way to control them and solicit sexual favors. For example, JANE DOE (WC) 2 remembers one girl needing to submit to sexual abuse by this employee as a way to get drugs and avoid withdrawal symptoms.

108. This staff member introduced JANE DOE (WC) 2 to drugs by giving her morphine.

109. He also used intimidation and fear to avoid detection. Not only did he tell JANE DOE (WC) 2 that no one would believe her; he also made her feel threatened by telling her she better not tell anyone or even try to tell anyone. Given that he was a large man with a key to her room, JANE DOE (WC) 2 believed this officer might try to kill her.

110. Since her abuse, JANE DOE (WC) 2 has dealt with depression, drug addiction, and sleeplessness. She has been prescribed sleep aid medication in the past. She struggles to develop trusting relationships with men.

THE ABUSE OF JOHN DOE (WC) 3

111. JOHN DOE (WC) 3 was ten years old when a male employee began sexually abusing and harassing JOHN DOE (WC) 3. Upon information and belief, Johnson was an officer at the facility.

112. The abuse, which occurred on at least three occasions, began in approximately 1978. Among other things, the officer entered JOHN DOE (WC) 3's room and forced himself on JOHN DOE (WC) 3. The officer disrobed JOHN DOE (WC) 3 and performed oral sex on JOHN DOE (WC) 3 and then forced JOHN DOE (WC) 3 to perform oral sex on the officer. Johnson then penetrated JOHN DOE (WC) 3.

113. The coerced JOHN DOE (WC) 3's silence by threatening to throw JOHN DOE (WC) 3 into "lock up," another word for the "cell lock" procedure where children were stripped naked and left alone for extended periods of time. This coerced JOHN DOE (WC) 3's silence, as he had already endured cell lock before, and he did not want to have to go through that traumatizing experience again.

THE ABUSE OF JANE DOE (WC) 4

114. JANE DOE (WC) 4 was fourteen years old when a female employee began sexually harassing and abusing her. Upon information and belief, the employee was an officer at the facility.

115. The abuse, which occurred on at least five occasions, began in approximately December 1997.

116. The abuse occurred in the shower, the day room, and the performance stage area. The officer would grope JANE DOE (WC) 4 on her breasts, vagina, and pubic area, and would masturbate to orgasm while JANE DOE (WC) 4 was forced to watch.

117. On one occasion, JANE DOE (WC) 4 was in the shower, and the officer came up to ger stated she wanted a "sample," before beginning to perform oral sex on JANE DOE (WC) 4.

118. On multiple other occasions, the officer set down next to JANE DOE (WC) 4 in a dayroom while she was watching a movie and put her hand down JANE DOE (WC) 4's clothing and groped her vagina, began to rub it, and then penetrated it with her fingers. The officer signaled to JANE DOE (WC) 4 to shush with her other hand.

119. On at least one occasion, the officer spilled cleaning solution on JANE DOE (WC) 4's clothing to force her to disrobe and shower.

120. The officer would bribe JANE DOE (WC) 4 with food and privileges to submit to the abuse and to keep quiet.

121. When JANE DOE (WC) 4 would not submit to the abuse when bribed, she would attempt to push the abuser away. The officer threatened JANE DOE (WC) 4, saying no one would believe her if she were to file a report.

122. Since the abuse at Waxter, JANE DOE (WC) 4 has suffered from depression. She has struggled to love people effectively and have positive, faithful relationships.

THE ABUSE OF JOHN DOE (WC) 5

123. JOHN DOE (WC) 5 was nine years old when a male employee began sexually abusing and harassing him. Upon information and belief, the employee was an officer or guard at the facility.

124. The abuse began in approximately 1993, and continued on at least sixteen occasions.

125. The guard started by bribing JOHN DOE (WC) 5 with candy to go into a room, away from other juveniles and staff, alone with the guard and another child. Once he had the two children alone in his room, the guard forced the children to remove all their clothes and the guard fondled JOHN DOE (WC) 5's genitals and buttocks.

126. While the guard started the abuse with bribes and privileges, he eventually turned to force and threats. By the end of JOHN DOE (WC) 5's time at Waxter, the guard held him down to abuse him and threatened to kill him and his family if he told anyone what happened.

127. Since his abuse, JOHN DOE (WC) 5 has struggled with suicidal ideation and depression.

THE ABUSE OF JANE DOE (WC) 6

128. JANE DOE (WC) 6 was 16 when she was sent to Waxter in 2001 for taking her mother's car for a joy ride. Shortly after arriving, she learned that staff performed strip searches routinely on the girls at the center, including before and after showers.

129. JANE DOE (WC) 6 was sexually harassed and abused by a correctional officer. The abuse, which occurred on at least four or five occasions, began a few months after her arrival at the center. Among other things, the officer would observe the strip searches, and then let himself into her locked room while she was dressing. There, he would touch her legs, grope her genitals, and penetrate her vagina with his fingers. In addition to her cell room, the officer abused her in a similar manner in other areas of the facility, including the room next to the showers.

130. Following the abuse, JANE DOE (WC) 6 struggled with addiction for years. She has been in and out of rehab a dozen times before finally getting clean a year ago. She has severe anxiety and depression related to her abuse and wrestles with PTSD more than 20 years after the abuse. To this day she finds it difficult to be around men she does not know.

THE ABUSE OF JOHN DOE (WC) 7

131. JOHN DOE (WC) 7 was sexually abused and harassed by a male employee. Upon information and belief, this employee was a guard or correctional officer employed by Defendant. The abuse, which occurred on at least six occasions, began in approximately 2001, when JOHN DOE (WC) 7 was 13 or 14 years old. Among other things, the employee forced JOHN DOE (WC) 7 into a bathroom supply closet where he grabbed JOHN DOE (WC) 7's testicles and then penetrated JOHN DOE (WC) 7's anus with his finger. The employee performed oral sex on JOHN DOE (WC) 7 On another occasion, the employee entered JOHN DOE (WC) 7's locked room on the ward and laid on top JOHN DOE (WC) 7. The employee then pulled JOHN DOE (WC) 7's boxers down and performed oral sex on him.

132. On another occasion, the employee followed JOHN DOE (WC) 7 into the shower area, when the boy was alone. As the boy was shampooing his hair, JOHN DOE (WC) 7 remembers distinctly the employee grabbing his testicles with one hand and using the other hand

to insert his finger in JOHN DOE (WC) 7's anus. As JOHN DOE (WC) 7 was attempting to push the employee off, the officer licked the boy's testicles and asked, "You like that?"

133. JOHN DOE (WC) 7 said it was no secret what this employee was doing with him and possibly other boys at the facility. There would be one officer at the end of the hall and this employee would go down the hall to "make his rounds," and enter JOHN DOE (WC) 7's room.

134. JOHN DOE (WC) 7 reported the sexual abuse more than once to his case manager; she promised to take action on the complaints, but the abuse continued unabated. In addition to the multiple sexual assaults, JOHN DOE (WC) 7 was threatened repeatedly by his abuser that there would be trouble if he reported the abuse. JOHN DOE (WC) 7 once tried to fill out a grievance form, only to learn that it had to be turned in to the guards themselves. Another time, the abuser learned from the case manager that the boy had reported the abuse; he came to the boy and said: "You're the one who's going to get in trouble."

135. On one occasion, the abuser made good on his threat. It was the day after JOHN DOE (WC) 7 reported the abuse. He and other boys were in the day room and JOHN DOE (WC) 7 was in an argument with another boy; they were both standing and exchanging barbs. The abuser came up behind JOHN DOE (WC) 7 and slammed his face down on a table, then pushed his body down on the floor and held him down. JOHN DOE (WC) 7 was taken to the hospital, where he received more than 20 stitches above his eye. That was the only time in 18 months at Waxter that he got to see his mother. When he returned to Waxter, he was placed in solitary. No one else, including the employee/abuser, got into any trouble.

136. JOHN DOE (WC) 7 has experienced significant trust issues over the years since his release from Waxter. He had suicidal thoughts while he was at Waxter and since. It took almost three years following the attack in the day room for his eye to return to normal function. The abuse

made JOHN DOE (WC) 7 ask why he was targeted, what kind of signal he gave off as a teen. He still has problems with his "nerves," and has dealt with blinding anger and crippling depression. He has been in therapy for years and has been on medication for depression.

137. He never finished high school after being released from Waxter.

THE ABUSE OF JANE DOE (WC) 8

138. JANE DOE (WC) 8 was fourteen years old when she was sent to Waxter after running away from a foster home; she had committed no crime. She spent 30 days at the center until a new placement for her was found. Within days, she observed that a few of the staff members would disappear into rooms with girls during their "rounds." Two of the officers, one male, one female, regularly watched the girls during their showers and followed them to their rooms.

139. After she had been at Waxter for a week, a male employee who was known as an activity coach began telling her he was available if she needed someone to talk to. Then one night he let himself into her room after showers, and sexually molested her, touching her and penetrating her with his fingers and raping her.

140. The abuse occurred on at least two occasions during JANE DOE (WC) 8's first stay at Waxter. After violating her probation, she was sent back to Waxter and learned she was pregnant. Her abuser visited her several more times when she was pregnant, despite her telling him of her condition.

141. JANE DOE (WC) 8 learned from other girls that one of the guards or counselors was abusing several of the girls. One day in the recreation room at Waxter, she saw him place restraints on one of these girls and had her "trussed up" and pressed up against his privates as he bent her over a pool table to allegedly get her under control during an altercation with another girl.

142. JANE DOE (WC) 8 also observed her abuser and another girl leave the rec room during a movie night and come back later, one after the other.

143. After her own abuse, JANE DOE (WC) 8 told her grandmother about the incidents over the phone and her grandmother called and threatened the facility's administrators. JANE DOE (WC) 8 was allowed to go home to her grandmother and at her next hearing she told the judge about what had occurred. The case worker, however, told the judge JANE DOE (WC) 8 is one of those children who lies about everything.

144. JANE DOE (WC) 8 was abused by the activity coach employee two or three times during her first stay at Waxter and two to three times more during her second stay, when she was pregnant.

145. JANE DOE (WC) 8's time at Waxter was in 1989. She still has problems with intimacy and is hyper vigilant about her children's safety. She dealt with addiction issues over the years and has received therapy following the sexual abuse for many years.

THE ABUSE OF JOHN DOE (WC) 9

146. JOHN DOE (WC) 9 was 14 years old when he was sent to Waxter after getting caught smoking pot at school. He was originally supposed to stay 30 days. A male employee began sexually abusing and harassing him about a week after his arrival. Upon information and belief, this employee was a guard or correctional officer at the facility.

147. One night in March of 1995, the employee entered JOHN DOE (WC) 9's room, which was locked from the outside, but to which he had a key. Once inside the room, he approached JOHN DOE (WC) 9 on his bed, pulled down his pants and grabbed JOHN DOE (WC) 9's penis with his bare hands.

148. On another evening, when the residents' rooms had been locked down for the night, the Waxter employee once again entered JOHN DOE (WC) 9's room, pulled JOHN DOE (WC) 9's pants down, and started to mount him. JOHN DOE (WC) 9 screamed and fought back until another employee knocked at the door to "make sure everything was alright." Later that evening, the abuser brought four other male juveniles into JOHN DOE (WC) 9's locked room to physically assault JOHN DOE (WC) 9 by punching and kicking him repeatedly. In the day room a few days later, the abuser and other staff, including JOHN DOE (WC) 9's probation officer, mocked him for getting beaten up. When he tried to tell his PO what had occurred, she laughed at him; when he talked back, he was immediately told he was getting another month at the facility.

149. JOHN DOE (WC) 9 had two more short stays at Waxter Children's Center over the following year for violating probation. Rather than leaving detention having "learned his lesson," JOHN DOE (WC) 9 returned home angry at the world. He began to self-medicate heavily and has been in therapy and on psychiatric medications for years to address the lasting damage of childhood sexual abuse.

150. The sexual abuse at Waxter "took my whole adolescence from me," said JOHN DOE (WC) 9, now 43. "I was really messed up by it. It still follows me to this day."

THE ABUSE OF JOHN DOE (WC) 10

151. Plaintiff JOHN DOE (WC) 10 was twelve years old when the abuse and harassment began by a female employee. On information and belief, she was a guard at Waxter.

152. JOHN DOE (WC) 10's abuse began in approximately 1983.

153. The guard made sure no one was around, went into JOHN DOE (WC) 10's room, told JOHN DOE (WC) 10 to take all his clothes off, and rubbed and touched JOHN DOE (WC)

10's genitals, bare handed. This happened about 8 times while JOHN DOE (WC) 10 was at the facility. This would last five to fifteen minutes each time and would take place around 10:00 pm.

154. At the end of every encounter, the guard would tell JOHN DOE (WC) 10, "if you know what's best for you, you will keep your mouth shut." This made JOHN DOE (WC) 10 feel afraid and threatened; she kept coming into his room and he never knew if she was going to hurt him.

155. On information and belief, when JOHN DOE (WC) 10's abuse began, this employee had already abused multiple other victims and been reported for sexual abuse. Nothing was done about the prior reports. When JOHN DOE (WC) 10 learned about this fact, he was further dissuaded from reporting.

156. Since his abuse at Waxter, JOHN DOE (WC) 10 has struggled with nightmares, flashbacks, and depression.

RESPONDEAT SUPERIOR

157. 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

158. While Maryland has partially waived immunity under the Maryland Tort Claims Act as amended by the Child Victims Act, Md. Code, State Gov't, § 12-104(a), to the extent claims herein trigger any governmental immunities, damages are sought only under and up to the amount of insurance coverage available.

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

COUNT I: NEGLIGENCE

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

161. At relevant times, Defendant was required to appropriately manage, supervise, and treat youth involved in the juvenile justice system in Maryland. 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.

162. 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.

163. These duties and obligations are statutorily mandated and are non-delegable. Even though Defendant has, through the years, contracted with third party providers (such as YSI and Rebound) as agents for some of these services, the ultimate responsibility for oversight, management and operations at all levels of the Waxter Children's Center remains with DJS, as assigned by the Legislature.

164. These duties and obligations require Defendant to meet applicable standards of care for facilities such as the Waxter Center under its operation and control.

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

166. 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 abuse; and

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

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

168. To the extent that Defendant selected and contracted with third-party providers, Defendant was negligent in selecting and contracting with said entities, whom it failed to properly vet to ensure suitability for the critical services to be provided.

169. The exact services third parties were contracted to provide, if they did so at Waxter, are currently unknown to Plaintiffs, who lack access to those contracts, but upon information and belief, such services would have included direct supervision, personal protection and care of youth at Defendant's facilities including but not limited to the Waxter Children's Center.

170. These third-party providers breached the national standards of care applicable to their services to youth, more specifically by hiring, failing to supervise, and continuously retaining unfit staff who perpetrated upon youth as set forth with specificity above.

171. The acts and omissions of any third-party providers selected and paid by Defendant are imputable to Defendant as principal/employer and holder of these non-delegable duties.

172. 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/or 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 II: NEGLIGENT HIRING, SUPERVISION, AND RETENTION

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

174. Defendant had statutory, mandated, non-delegable duties regarding hiring staff at all levels within its management and operation of juvenile justice facilities, including the Waxter Children's Center. Md. Code, Hum. Serv. § 9-201 *et seq.*

175. Defendant directly hired individuals at executive levels to oversee, manage and operate juvenile justice facilities including the Waxter Children's Center.

176. In addition, Defendant selected and hired both direct employees and third-party agents and providers to oversee, manage, and operate the Waxter Children's Center.

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

178. 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 the Waxter Children's Center and other facilities under its control.

179. Defendant breached this duty and others by hiring, either directly or through third-party providers, not only unqualified and incompetent executives, providers and staff, but in some cases dangerous individuals with known criminal backgrounds and/or readily ascertainable histories of abusing youth in other facilities.

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

181. Defendant would have known of these providers' and 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 in their care, including Plaintiffs.

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

183. Defendant breached this duty by failing to monitor and supervise their direct staff and the performance of third-party providers and their staff to ensure that sexual abuse was not occurring.

184. Defendant and/or its selected third-party providers breached this duty by failing to investigate complaints both by youth residents and by independent evaluators that staff and youth at the Waxter Children's Center and other facilities under their control were perpetrating sexual abuse upon residents, including Plaintiffs.

185. Defendant and its selected third-party providers each 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.

186. Defendant and/or its selected third-party providers breached this duty by continuously retaining both its direct staff members and third-party providers' staff members whom they knew or should have known had dangerous propensities and/or had sexually abused youth.

187. Each of these breaches violated Defendant's statutorily mandated duties and applicable standards of care, as well as standards of care applicable to third-party providers.

188. DJS had the power to terminate its direct employees and, at minimum, power to terminate its contract with any third-party provider who failed to protect youth from sexual abuse.

189. Defendant failed to exercise this power and was negligent in both the supervision and retention of its direct employees and those of the third-party providers with whom it contracted.

190. Defendant failed to promptly terminate the contracts with third-party providers despite actual or constructive knowledge of the sexual abuse the providers' staff were perpetrating upon youth, including Plaintiffs.

191. 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.

192. Had Defendant's selected third-party providers 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.

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

194. 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/or disfigurement, past and continuing into the future;

b. Severe emotional distress, including pain and suffering, 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 III: NEGLIGENT FAILURE TO TRAIN AND EDUCATE

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

196. 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.

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

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

199. 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.

200. While Defendant was permitted to hire third- party providers to carry out its work, Defendant retained at all times a duty to ensure that the staff of third- party providers were properly trained in regard to protecting children from sexual abuse.

201. Because these duties originate by statute and at the direction of the Maryland Legislature, Defendant cannot fully abdicate the ultimate responsibility to protect minors in its care, even when it hires third -party providers.

202. Defendant or others acting on its behalf or under its direction or control (both direct and third-party providers), 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 its staff, employees, and/or agents (direct and third parties) on behaviors constituting sexual abuse by staff and/or among residents;

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

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

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

g. Failing to properly train or educate its staff, employees, or 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.

203. 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.

204. 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/or disfigurement, past and continuing into the future;

b. Severe emotional distress, including pain and suffering, 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 IV: GROSS NEGLIGENCE

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

206. 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. This was equally true in regard to direct hires and anyone employed by third party providers.

207. In turn, all third-party providers had a duty to hire and retain only qualified staff to serve youth in Defendant's juvenile facilities.

208. Defendant and its selected third-party providers, separately and jointly, intentionally failed to act on literally decades of complaints and allegations both from youth residents and independent evaluators which informed them that numerous staff had, and were continuing to, perpetrate sexual abuse upon the youth in their care.

209. 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.

210. As such, Defendant and its selected third-party providers, or one or more of them, were grossly negligent in failing to perform their statutorily mandated, nondelegable and assumed duties to protect Plaintiffs and other youth from sexual abuse.

211. As a result of this gross negligence, the sexual abuse at the Waxter Children's Center was tolerated, and proliferated among more and more staff as years went on.

212. 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/or disfigurement, past and continuing into the future;

b. Extreme 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. R. Civ. Pro. Cir. Ct. 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 V: PREMISES LIABILITY

213. Plaintiffs incorporate and reallege all paragraphs of this Complaint into this Count.

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

215. Defendant knew or should have known of the risk that its staff, /employees, and/or agents (either its direct hires, or those of its selected third-party providers) 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.

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

217. 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.

218. 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 its staff, employees, and/or agents (direct and those of its selected third -party providers) and/or residents who perpetrated sexual abuse upon Plaintiffs.

219. 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 (and others staffed by its

selected third- party providers) prior to the actual sexual abuse of Plaintiffs, all of which made imminent harm foreseeable.

220. 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 and harassment;

b. Improperly protecting Plaintiffs, then minors, from sexual abuse and harassment;

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

d. Ignoring and/or otherwise failing to properly address complaints about numerous instances of sexual assaults occurring in Waxter;

e. Failing to promptly report Plaintiffs' sexual assaults to the authorities;

f. Failing to take any action to prevent retaliation against Plaintiffs after their assaults were reported to Waxter;

g. Failing to conduct an exit interview with Plaintiffs when they left Waxter;

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

i. Retaliating against Plaintiffs for reporting that they were sexually assaulted by subjecting them to arbitrary, capricious, and unwarranted "discipline" for pretextual reasons that masked the discriminatory nature of the facilities' treatment of them; and

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

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

222. Defendant's conduct was wanton, malicious, or oppressive, or Defendant disregarded or exhibited reckless indifference to the foreseeable risks of harm and acted with ill will, hatred, hostility, a bad motive, or the intent to abuse its power.

223. 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/or 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 VI: ARTICLE 24 MARYLAND DECLARATION OF RIGHTS – SUBSTANTIVE DUE PROCESS

224. The proceeding paragraphs are incorporated as though fully set forth herein.

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

226. The Maryland Constitution and principles of *respondeat superior* require Defendant to avoid Constitutional violations by its employees, staff and agents through adequate training and supervision and by disciplining employees, staff, and agents for unlawful conduct.

227. 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 the Waxter Center.

228. All the perpetrators' actions occurred within the course of their duty and within the scope of their employment at Waxter Children's Center.

229. Plaintiffs have a substantive due process right to bodily autonomy.

230. The perpetrators repeatedly violated Plaintiffs' rights under Article 24.

231. Defendant is vicariously liable for the perpetrators' violations of Plaintiffs' rights under Article 24.

232. Defendant therefore deprived Plaintiffs of their right to bodily autonomy under Article 24 when the perpetrators repeatedly sexually abused Plaintiffs.

233. As a direct and proximate cause of Defendant's unconstitutional conduct, Plaintiffs were deprived of their substantive due process rights to bodily autonomy.

234. 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)

235. The proceeding paragraphs are incorporated as though fully set forth herein.

236. It is the custom and practice of the State of Maryland, DJS, and Waxter Center to permit its employees, staff, and/or agents to violate children's substantive due process rights to bodily integrity by physically and sexually abusing them.

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

238. Defendant's failure to supervise demonstrates gross disregard for and deliberate indifference to Plaintiffs' Constitutional rights.

239. Defendant's failure to train and supervise Waxter Children's Center employees, staff, and/or agents Waxter staffers is so patently obvious from the repeated sexual abuse that Plaintiffs and other children at Waxter Center have experienced for decades.

240. As a result of the failure to train and supervise, and the permitted pattern of practice at Waxter, Defendant's employees, staff, and/or agents were allowed to sexually assault children.

241. Defendant's Waxter Center employees, staff, and/or agents failed to report these incidents of reckless and intentional unlawful conduct, and the State or Maryland and Defendant lacked effective procedures to control or monitor its Waxter employees, staff, and/or agents/staffers who had a pattern or history of unlawful behavior.

242. The State of Maryland and Defendant caused its Waxter Center employees, staff, and/or agents to believe that unlawful sexual abuse would not be aggressively, honestly, and properly investigated.

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

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

245. 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.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray unto the Court:

1. Enter judgment against Defendant in favor of the Plaintiffs for a sum in excess of $30,000, jointly and severally;
2. For a trial by jury on all issues so triable;
3. That the costs, including expert witness fees, of this action be taxed against Defendant;
4. Pre-judgment interest and post-judgment interest;
5. For reasonable attorneys' fees as allowed by law; and
6. For such other and further relief as the Court deems just and proper.

This the 1st day of October, 2023.

Respectfully submitted,

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