Department of Justice Activities
Under the
Civil Rights of Institutionalized Persons Act
Fiscal Year 2010

Table of Contents

I. Introduction and Overview

Individuals confined in institutions are often among the most vulnerable in our society. Recognizing the need to protect the rights of those residing in public institutions, Congress in 1980 passed the Civil Rights of Institutionalized Persons Act (CRIPA), giving the Attorney General the authority to investigate conditions at certain residential institutions operated by state and local governments—including facilities for individuals with psychiatric or developmental disabilities, nursing homes, juvenile justice facilities, and adult jails and prisons—to determine whether there are violations of the Constitution or federal laws. In institutions for people with disabilities, the U.S. Department of Justice (DOJ), Civil Rights Division also has the authority to examine whether individuals are improperly confined to the institution when they could appropriately receive services in community-based settings.

If a pattern or practice of unlawful conditions deprives individuals confined in the facilities of their constitutional or federal statutory rights, the Division can take action. As required by the statute, the Division engages in negotiation and conciliation efforts and provides technical assistance to help jurisdictions correct deficient conditions. If these efforts fail, the Division may file a lawsuit to correct the violations of rights.

The Division takes very seriously its responsibility to protect the rights of individuals residing in institutions, and has been engaged in an effort to ramp up enforcement efforts. In Fiscal Year 2010, the Division filed three lawsuits under CRIPA and entered into four consent decrees. The Division also initiated investigations of nine facilities and issued seven findings letters outlining findings of significant constitutional and federal statutory violations at 11

facilities.[1] At the end of Fiscal Year 2010, the Division had active CRIPA matters and cases involving 162 facilities in 31 states, the District of Columbia, the Commonwealths of Puerto Rico and the Northern Mariana Islands, and the Territories of Guam and the Virgin Islands. As envisioned by Congress, enforcement of CRIPA continues to identify egregious and flagrant conditions that subject residents of publicly operated institutions to grievous harm. 42 U.S.C. § 1997a (a). In addition to its enforcement efforts at state and local facilities, pursuant to Section f(5) of CRIPA, the Division provides information regarding the progress made in each federal institution (specifically from the Bureau of Prisons and the Department of Veterans Affairs) toward meeting existing promulgated standards or constitutionally guaranteed minima for such institutions. (See Appendices A and B.)

The year 2010 proved to be a landmark year for federal enforcement of the Supreme Court's decision in Olmstead v. L.C., 527 U.S. 81 (1999) , a ruling requiring states to eliminate unnecessary segregation of people with disabilities and to move people who can live in the community out of segregated facilities. Using its authority under both CRIPA and the Americans with Disabilities Act (ADA), the Division vigorously enforced the ADA right to community integration by initiating investigations, issuing violation findings, filing lawsuits and motions for preliminary injunctions, filing *amicus* briefs and statements of interest in support of private *Olmstead* cases, and entering into settlements and monitoring implementation of ongoing settlements with community integration requirements. For example, the Division prosecuted two complex Olmstead lawsuits late in the fiscal year. One six week trial involved, among other things, the right of persons with developmental disabilities confined in an Arkansas institution to

[1] The full text of these findings letters may be found at the Division's website at http://www.usdoj.gov/crt/split/index.html.

be served in the most integrated setting appropriate to their needs. The second case, an emergency action to protect the safety and Olmstead rights of all persons with mental illness or developmental disabilities confined in Georgia's institutions, resulted in a landmark settlement shortly after the end of the fiscal year.

II. Filing of CRIPA Complaints/Resolution of Investigations and Lawsuits

A. Cases Filed to Resolve Investigations

1. *Kings County, NY*

In January 2010, the Division reached an agreement with New York City to correct conditions of confinement at the Kings County Hospital Center's (KCHC) psychiatric emergency room and psychiatric in-patient units in Brooklyn, N.Y. The agreement was filed simultaneously with a complaint in United States v. New York, CV-10-0060 (E.D.N.Y). An investigation of the psychiatric units uncovered systemic deficiencies that violated the constitutional and civil rights of individuals with psychiatric disabilities. These violations included failure to protect individuals from harm, failure to treat individuals' psychiatric disabilities, the use of drugs to sedate rather than treat individuals, failure to provide adequate and individualized discharge planning and follow-up services, falsification of medical records, and failure to respond promptly to medical emergencies. These violations and others contributed to the death of at least one individual, in June 2008, who collapsed in the psychiatric emergency room after waiting 23 hours to be seen by a doctor. The agreement, in the form of a consent judgment, requires New York City to work to ensure that individuals at KCHC are safe and receive the care and services necessary to meet their individual needs. The City agreed to undertake a variety of measures; including improving medical and mental health care and ensuring that individuals are free from undue restraint.

The agreement also underscores the City's obligation to actively pursue discharge of individuals to the most integrated setting appropriate based on their needs and to ensure that adequate follow-up services are provided, consistent with the requirements of the ADA and the Supreme Court's Olmstead ruling.

2. ***Cook County, IL***

In May 2010, the Division reached a comprehensive, cooperative agreement with Cook County, IL, and the Cook County Sheriff to resolve findings of unconstitutional conditions at the Cook County Jail. The agreement was filed simultaneously with the complaint in United States v. Cook County, IL, 10-cv-2946 (N.D. Ill. 2010). An investigation found that the Jail systematically violated inmates' constitutional rights through the use of excessive force by staff, failure to protect inmates from harm by fellow inmates, inadequate medical and mental health care, and a lack of adequate fire safety and sanitation. The Jail is the nation's largest single-site county jail, consisting of multiple buildings located on 96 acres on Chicago's West Side, with an average daily population of more than 8,500 adult male and female inmates. Under the agreement, Cook County and the Sheriff will implement detailed remedial measures to ensure that inmates are safe and receive the services necessary to meet their constitutional rights, including hiring more than 600 additional correctional officers over the next year. Other highlights include comprehensive provisions aimed at changing the Jail's permissive culture surrounding the excessive use of force and at improving policies, procedures and practices to protect inmates from harm by providing adequate medical and mental health care, fire and suicide prevention, sanitation, and employee training.

3. *New York*

In July 2010, the Division reached an agreement with the State of New York and the New York Office of Children and Family Services to resolve findings of unconstitutional conditions at four juvenile justice facilities. The consent decree was filed simultaneously with the complaint in United States v. New York, 10-CV-858 (N.D.N.Y.). The Division's investigation found that the facilities systematically violated juveniles' constitutional rights in the areas of protection from harm and mental health care. The findings concluded that staff at the facilities consistently and excessively used a disproportionate degree of force to gain control of youths in nearly every type of situation, leading to concussions, broken or knocked out teeth, spiral fractures, and other injuries. Further, staff at the facilities overused restraints, often causing severe injury to youths, and the facilities consistently failed to investigate uses of force and failed to properly discipline staff found to have used excessive force. The investigation also found that the facilities failed to provide adequate behavioral management programs and treatment plans. Staff generally ignored youths' substance abuse or dependence problems. The State failed to properly equip staff to address youths in mental health crisis. And, psychotropic medications were prescribed without appropriate monitoring of potentially dangerous side effects.

The agreement requires New York to implement detailed remedial measures to ensure that juveniles are safe and receive the services necessary to meet their constitutional rights. It also severely restricts the use of force, including express prohibitions on chokeholds and "hooking and tripping" techniques. Pursuant to the agreement, New York must conduct appropriate investigations of excessive force allegations and implement improved policies, procedures, and practices to protect juveniles from harm. Significant improvements required include: providing adequate mental health care; ensuring that the use of psychotropic medication is safe and clinically

appropriate; addressing substance abuse and dependence issues; and instituting comprehensive employee training requirements.

B. **Contested Litigation**

1. ***Erie County, NY***

On September 30, 2009, the Division filed suit in United States v. Erie County, New York, 1:09-CV-000849 (W.D. N.Y. 2009), regarding conditions at the Erie County Holding Center, a pre-trial detention center in Buffalo, NY, and the Erie County Correctional Facility, a correctional facility in Alden, NY. The complaint alleged unconstitutional conditions at the facilities, including: staff-on-inmate violence, inmate-on-inmate violence, sexual misconduct between staff and inmates, sexual misconduct among inmates, inadequate systems to prevent suicide and self-injurious behavior, inadequate medical and mental health care, and serious deficiencies in environmental health and safety.

Since 2005, there have been eight suicides at the holding center, including three suicides that occurred after DOJ filed its complaint. As part of its litigation, the United States' suicide prevention expert found that the suicide rate at the holding center was five times the national average. In June 2010, the Division reached a stipulated settlement agreement resolving a portion of the lawsuit regarding the limited issue of suicide prevention and related mental health care. The agreement addressed the County's inadequate system of suicide prevention and self-injurious behavior of holding center inmates. Under the agreement, Erie County and the Sheriff will implement detailed remedial measures to ensure that holding center inmates are protected from suicide hazards. Among these measures, the County will improve screening and assessment, provide suicide prevention and detoxification training to holding center staff, improve communication and record keeping, provide safe housing, and establish a risk management system

that identifies and corrects deficiencies on an ongoing basis. Litigation regarding all other aspects of the lawsuit is ongoing.

2. ***Georgia***

On January 15, 2009, the Division filed a complaint and settlement in United States v. Georgia, 1:09-CV-0119 (N.D. Ga. 2009) regarding conditions and healthcare practices at the Georgia Regional Hospital in Atlanta, GA, a state-operated facility serving individuals with mental illness and developmental disabilities. The complaint alleged that the State failed to protect individuals from serious harm and undue risk of serious harm by failing to provide adequate medical and mental health services, and that the State failed to provide services in the most integrated setting appropriate to individual needs. In the settlement filed with the complaint, the State agreed to reforms at Georgia's seven state facilities for persons with mental illness or developmental disabilities, including protection from harm, mental health care, seclusion and restraint practices, medical and nursing care, education, special education, limited English proficiency services, and discharge planning.

After monitoring conditions in the hospitals, the Division found that the facilities continued to be dangerous and that hundreds of individuals who could and should be served in the community remained institutionalized and continued to be exposed to dangerous conditions. In January 2010, the Division filed a motion for immediate relief to protect individuals confined in these psychiatric hospitals from the imminent and serious threat of harm to their lives, health and safety.

Following the Division's motion, the parties worked together to reach an agreement to transform the State's mental health and developmental disability system. On November 1, 2011, the Court entered the agreement covering remedies for violations of the ADA in United States v.

Georgia, 1:10-CV-0249 (N.D. Ga. 2010) as an order of the court. It expands community mental health services so that Georgia can serve individuals with mental illness and developmental disabilities in the most integrated setting appropriate to those individuals' needs. The settlement was the most comprehensive ever reached in an Olmstead case.

3. ***Conway, Arkansas***

On September 8, 2010, in United States v. Arkansas (E.D. Ark.), the Division began a six week bench trial regarding violations of the constitutional and statutory rights of individuals at the Conway Human Development Center in Conway, AR. The Division brought this CRIPA lawsuit in 2009 to remedy constitutional violations as well as ADA and IDEA statutory violations. The Division presented the testimony of 30 expert and lay witnesses regarding the State's failure to serve individuals at Conway in the most integrated setting appropriate to their needs, and the facility's failure to provide adequate protection from harm, medical and mental health services, physical and nutritional management and special education services. The Division is seeking permanent injunctive relief requiring the State to take actions that will ensure lawful conditions at Conway and compliance with the IDEA and the integration mandate of the ADA. The Division is awaiting the court's ruling.

III. Prison Litigation Reform Act

The Prison Litigation Reform Act (PLRA), 18 U.S.C. § 3626, enacted on April 26, 1996, covers prospective relief in prisons, jails, and juvenile justice facilities. The Division has defended the constitutionality of the PLRA and has incorporated the PLRA's requirements in the remedies it seeks regarding improvements in correctional and juvenile justice facilities.

IV. Compliance Evaluations

During Fiscal Year 2010, the Division monitored defendants' compliance with CRIPA consent decrees, settlement agreements, and court orders designed to remedy unlawful conditions in numerous facilities throughout the United States. These facilities are:

A. Facilities for persons with developmental disabilities:

Facility or Facilities	Case or Agreement	Court/Date
Southbury Training School	United States v. Connecticut, N-86-252	D. Conn. 1986
Arlington Developmental Center	United States v. Tennessee, 92-2026HA	W.D. Tenn. 1992
Clover Bottom Developmental Center and Harold Jordan Center	United States v. Tennessee, 3:96-1056	M.D. Tenn. 1996
Centro de Servicios Multiples Rosario Bellber	United States v. Commonwealth of Puerto Rico, 99-1435	D. P.R. 1999
Glenwood Resource Center and Woodward Resource Center	United States v. Iowa, 04-CV-636	S.D. Iowa. 2004
Woodbridge Developmental Center	United States v. New Jersey, 3:05-CV-05420(GEB)	D. N.J. 2005
Oakwood Community Center	United States v Kentucky, 3:06-CV-63	E.D. Ky. 2006
Frances Haddon Morgan and Rainier Developmental Centers, Washington	2007 Settlement	N/A
Beatrice State Developmental Center	United States v. Nebraska, 08-08CV271-RGK-DL	D. Neb. 2008
Abilene State School; Austin State School; Brenham State School; Corpus Christi State School; Denton State School; El Paso State Center; Lubbock State School; Lufkin State School; Mexia State School; Richmond State School; Rio Grande State Center; San Angelo State School; and San Antonio State School	United States v. Texas, A-09-CA-490	E.D. Tex. 2009

B. Facilities for persons with mental illness:

Facility or Facilities	Case or Agreement	Court/Date
Guam Adult Mental Health Unit	United States v. Territory of Guam, 91-00-20	D. Guam 1991
Vermont State Hospital	United States v. Vermont, 2:06-CV-1431	D.Vt. 2005
Metropolitan State Hospital, Napa State Hospital, Atascadero State Hospital, and Patton State Hospital	United States v. California, 06-2667 GPS	M.D. Cal. 2006
St. Elizabeth's Hospital	United States v. District of Columbia, 1:07-CV-0089	D. D.C. 2007
Georgia Regional Hospital in Atlanta, Georgia Regional Hospital in Savannah, Northwest Georgia Regional Hospital, Central State Hospital, Southwest State Hospital, West Central Georgia Regional Hospital and East Central Georgia Regional Hospital.	United States v. Georgia, 1-09-CV-0119	N.D. Ga. 2009
Connecticut Valley Hospital	United States v. Connecticut, 3:09-CV-00085	D. Conn. 2009
Kings County Hospital Center	United States v. Kings County, New York, CV-10-0060	E.D.N.Y. 2010

C. Nursing Homes:

Facility or Facilities	Case or Agreement	Court/Date
Reginald P. White Nursing Facility	United States v. Mississippi, 3:04-CV933BN	S.D. Miss. 2004
Ft. Bayard Medical Center and Nursing Home	United States v. New Mexico, CV-07-470 WJ/DIS	D. N.M. 2007
Laguna Honda Hospital and Rehabilitation Center, California	2008 Settlement	N/A
C.M. Tucker Nursing Care Center	United States v. South Carolina, 3:09-CV-98	D.S.C. 2009
Tennessee State Veterans Home in Humboldt, Tennessee and Tennessee State Veterans Home in Murfreesboro, Tennessee	United States v. Tennessee, 1:09-CV-01012	W.D. Tenn. 2009

D. Juvenile justice facilities:

Facility or Facilities	Case or Agreement	Court/Date
Bayamon Detention Center, Centro Tratamiento Social Bayamon, Centro Tratamiento Social Humacao, Centro Tratatmiento Social Villalba, Centro Tratamiento Social Guayama, Guali Group Home, and Ponce Detention and Social Treatment Center for Girls	United States v. Commonwealth of Puerto Rico, 9 4-2080 CCC	D. P.R. 1994
Kagman Youth Facility	United States v. Commonwealth of the Northern Mariana Islands, CV-99-0017	D. N. Mar. I. 1999
Arkansas Juvenile Assessment and Treatment Center	United States v. Arkansas, 03CV00162	E.D. Ark. 2003
Oakley Training School	United States v. Mississippi, 3:03 CV 1354 BN	S.D. Miss. 2003
Central Juvenile Hall, Los Padrinos Juvenile Hall, and Barry J. Nidorf Juvenile Hall, California	2004 Settlement Agreement	N/A
Logansport Juvenile Intake/Diagnostic Facility and South Bend Juvenile Correctional Facility	United States v. Indiana, 1:06-CV-0201-RLY-T	S.D. Ind. 2006
Hawaii Youth Correctional Facility	United States v. Hawaii, 1:06-CV-00073-SPK-L	D. Haw. 2006
L.E. Rader Center	United States v. Oklahoma, 06-CV-673-TCK FHM	E.D. Okla. 2006
Baltimore City Juvenile Justice Center	United States v. Maryland, 1:05-CV-01772	D. Md. 2007
Evins Regional Juvenile Center	United States v. Texas, 7:08-CV-00038	S.D. Tex. 2008
Marion County Superior Court Juvenile Detention Center	United States v. Marion County Superior Court, Indiana, 1:08-CV-0460-LJM-T	N.D. Ind. 2008
Circleville Juvenile Correctional Facility, Indian River Juvenile Correctional Facility, Cuyahoga Hills Juvenile Correctional Facility, Mohican Juvenile Correctional Facility, Ohio River Valley Juvenile Correctional Facility, Freedom Center, Scioto Juvenile Correctional Facility, and Marian Juvenile Detention Center	United States v. Ohio, C2 08 0475	S.D. Ohio 2008
Los Angeles County Juvenile Camps	2009 Settlement Agreement	N/A

Lansing Residential Center, Louis Gossett, Jr. Residential Center, Tryon Residential Center, and Tryon Girls Center	United States v. New York, 10-CV-858	N.D.N.Y. 2010

E. Jails:

Facility or Facilities	Case or Agreement	Court/Date
Hagatna Detention Center and Fibrebond Detention Facility	United States v. Territory of Guam, 91-00-20	D. Guam 1991
Harrison County Jail	United States v. Harrison County, Mississippi, 1:95 CV5-G-R	S.D. Miss. 1995
Sunflower County Jail	United States v. Sunflower County, Mississippi, 4:95 CV 122-B-O	S.D. Miss. 1995
Coffee County Jail, Georgia	1997 Settlement Agreement	N/A
Saipan Detention Facility, Tinia Detention Facility, and Rota Detention Facility	United States v. Commonwealth of the Northern Mariana Islands, CV 99-0017	D. N. Mar. I. 1999
Muscogee County Jail, GA	United States v. Columbus Consolidated City/County Government, Georgia, 4-99-CV-132	M.D. Ga. 1999
McCracken County Regional Jail	United States v. McCracken County, Kentucky, 5:01CV-17-J	W.D. Ky. 2001
Shelby County Jail	United States v. Shelby County, Tennessee, 02-2633DV	W.D. Tenn. 2002
Los Angeles Mens Central Jail, California	2002 Settlement Agreement	N/A
Dallas County Jail	United States v. Dallas County, Texas, 307 CV 1559-N	N.D. Tex. 2007
Terrell County Jail	United States v. Terrell County, Georgia, 04-cv-76	M.D. Ga. 2007
Baltimore City Detention Center, Maryland	2007 Agreement	N/A
Garfield County Jail, Oklahoma	2008 Settlement Agreement	N/A
Wilson County Jail, Tennessee	2008 Settlement Agreement	N/A
Santa Fe County Adult Detention Center	United States v. Santa Fe County, New Mexico, 1:08-CV-00212	D. N. Mex. 2008
Oahu Community Correctional Center	United States v. Hawaii, CV-08-00585	D. Haw. 2008

King County Correctional Facility	United States v. King County, Washington, CV-9-0059	W.D. Wash. 2009
Sebastian County Detention Center, Arkansas	2009 Settlement Agreement	N/A
Grant County Detention Center, Kentucky	2009 Settlement Agreement	N/A
Oklahoma County Jail and Jail Annex	2009 Settlement Agreement	N/A
Cook County Jail	United States v. Cook County, Illinois, 10-cv-2946	N.D. Ill. 2010

F. Prisons:

Facility or Facilities	Case or Agreement	Court/Date
Golden Grove Correctional and Adult Detention Facility	United States v. Territory of the Virgin Islands, 86-265	D. V.I. 1986
Saipan Prison Complex	United States v. Commonwealth of the Northern Mariana Islands, CV-99-0017	D. N. Mar. I. 1991
Guam Adult Correctional Facility	United States v. Territory of Guam, 91-00-20	D. Guam 1991
Delaware Correctional Center, Howard R. Young Correctional Institution, Sussex Correctional Institution, and Delores J. Baylor Women's Correctional Facility, Delaware	2007 Agreement	N/A
Taycheedah Correctional Institution	United States v. Doyle, 08-C-0753	E.D. Wis. 2008

V. Termination of CRIPA Cases

In Fiscal Year 2010, [8 CRIPA cases were dismissed after jurisdictions successfully came into compliance with settlement agreements and court orders. For example, in November 2009, the court dismissed United States v. Shelby County, TN, the Division's CRIPA case involving conditions at the Shelby County Jail in Memphis, TN. The settlement required the County to address findings of unconstitutional conditions that included failure to protect inmates from assault, egregiously deficient sanitation and environmental conditions, and inadequate medical and mental health care. The County's successful reform effort led to lifting of court supervision in this case and in separate private litigation. and to accreditation from the National Commission

on Health Correctional Care and the American Correctional Association, a distinction held by a minority of jails in the country.

Similarly, in United States v. Santa Fe County, the County and the Division jointly moved to dismiss the case in December 2009, after the Division found that the County had corrected unlawful conditions at the Santa Fe County Adult Detention Facility ("SFCADF"). SFCADF is a 672 bed facility for male and female adult pre-trial detainees and sentenced inmates charged with misdemeanors and/or felonies. Our investigation found constitutional deficiencies in medical and mental health care, suicide prevention practices, security administration, environmental health and safety, and access to courts. Tragedies at SFCADF included numerous inmate deaths and serious injuries from inmate-on-inmate assaults, suicides and suicide attempts, and inadequate medical screening and care. In accordance with the agreement, Santa Fe County implemented reforms in the areas of security and inmate safety, medical care, mental health care, sanitation, and suicide prevention. Advances realized under the settlement agreement included significant improvements in the facility's staffing and supervision, accountability procedures, training, and infection control. Improvements to the facility's medical and mental health screening and care saved lives, especially with regard to enhanced emergency care, and policies and procedures designed to identify and treat inmates at risk for serious medical complications from alcohol withdrawal.

In April 2010, in United States v. Iowa, the Division successfully ended its oversight of two State-operated institutions for individuals with developmental disabilities, Glenwood and Woodward Resource Centers ("Glenwood" and "Woodward"). Both facilities achieved substantial compliance with a CRIPA consent decree requiring significant reforms, under the ADA, in the State's provision of services to individuals in the most integrated setting appropriate

to their needs, and in the provision of constitutionally adequate care at the two facilities. The consent decree was entered in 2004, following a CRIPA investigation that found that the State had failed to provide individuals at these facilities with services in the most integrated, appropriate settings; failed to protect individuals from harm; failed to provide adequate medical and mental health care; inappropriately used restraints and seclusion; and failed to provide adequate treatment and training, including discharge planning and aftercare services. Under the Division's monitoring of the consent decree, the State focused its treatment planning process on returning individuals to community settings and supporting them there, reducing the facilities' census in the process; made enormous improvements in care at these facilities; vastly improved the facilities' protections from abuse and neglect; drastically reduced the use of restraints and ended the use of seclusion; developed exemplary care services for persons with significant positioning and swallowing needs; and provided timely, appropriate, and well-integrated supports and services to individuals living at these facilities.

In United States v. Tennessee, 1:09-CV-01012 (W.D. Tenn. 2009), a CRIPA case involving two Tennessee State Veterans' Homes ("TSVHs"), the State corrected unlawful conditions, and the Division joined with the State to dismiss the case in July 2010. The TSVHs are 150-bed nursing homes primarily serving veterans or veterans' family members. During our investigation, the Division found several life-threatening conditions at both nursing homes, including individuals who were dying due to inadequate medical care and malnourishment. In response to these findings, the State made significant improvements. For example, the State entered into an arrangement with Vanderbilt University to implement an extensive staff training program to address the deficient conditions. The TSVHs also implemented an improved dementia-care program; added key clinical staff, including medical directors certified in geriatric

care and experienced and qualified consultant psychiatrists; installed a state-of-the-art electronic health care record keeping system at both facilities to assist staff to better identify, monitor, and evaluate care; and improved psycho-social programs to better care for the mental health needs of individuals at the TSVHs.

In 2002, the Division commenced an investigation of conditions at two Maryland juvenile justice facilities, the Charles H. Hickey, Jr. School ("Hickey") and the Cheltenham Youth Facility ("CYF"). In 2005, in United States v. Maryland, the Division entered into a settlement agreement with the State calling for various reforms at the facilities. In 2005, the Division also commenced a separate investigation of conditions at the Baltimore City Juvenile Justice Center ("BCJJC"), which was resolved in 2007 by amending the complaint and modifying the settlement agreement to include BCJJC. At the pinnacle of the Division's compliance activities with the State in 2007, our settlement agreement involved three juvenile justice facilities and 81 substantive remedial provisions that included remedial measures related to protection from harm, medical care, mental health care, special education services, fire safety, and quality assurance. Between 2005 and 2010, the Division worked closely with the State to improve conditions and monitor the State's progress. After concluding that the State had fulfilled all of its obligations under the agreement, the Division, with the State, filed a joint motion for an order of final dismissal, which was approved and signed by the court in August 2010.

During Fiscal Year 2010, the Division also closed Southbury Training School (United States v. Connecticut, N-86-252 (D. Conn. 1986)); Central Juvenile Hall, Los Padrinos Juvenile Hall, and Barry J. Nidorf Juvenile Hall, California (2004 Settlement Agreement); Mercer County Geriatric Center (United States v. Mercer County, New Jersey, 05-1122 (D. N.J. 2005)); Logansport Juvenile Intake/Diagnostic Facility and South Bend Juvenile Correctional Facility

(United States v. Indiana, 1:06-CV-0201-RLY-T (S.D. Ind. 2006)); Frances Haddon Morgan Developmental Center, Washington (2007 Settlement Agreement); and Garfield County Jail, Oklahoma (2008 Settlement Agreement).

VI. New CRIPA Investigations

The Division initiated four CRIPA investigations during Fiscal Year 2010 involving the following facilities:

- LaSalle County Nursing Home, Illinois;
- Arkadelphia Human Development Center, Arkansas;
- Boonville Human Development Center, Arkansas;
- Alexander Human Development Center, Arkansas;
- Jonesboro Human Development Center, Arkansas;
- Southeast Arkansas Human Development Center, Arkansas;
- Casa del Veterano Nursing Home, Puerto Rico; and
- Robertson County Detention Center, Tennessee.

VII. Findings Letters

During the Fiscal Year, the Division issued seven findings letters regarding 11 facilities, setting forth the results of its investigations, pursuant to Section 4 of CRIPA, 42 U.S.C. § 1997b, including:

- Rosewood Center, Maryland;
- W.A. Howe Developmental Center, Illinois;
- Clyde L. Choate Developmental Center, Illinois;
- Westchester County Jail, New York;
- Lake County Jail, Indiana;

- Georgia Mental Health facilities:

  Georgia Regional Hospital, Savannah;

  East Central Regional Hospital,-Augusta;

  Central State Hospital, Milledgeville;

  Southwestern State Hospital, Thomasville; and

  West Central Georgia Regional Hospital, Columbus; and

- Indianapolis Juvenile Correctional Facility, Indiana.

In these investigations, the Division made significant findings of constitutional and federal statutory deficiencies. As envisioned by Congress, enforcement of CRIPA continues to identify conditions that subjects residents of publicly operated institutions to grievous harm. 42 U.S.C. § 1997a (a).

VIII. Investigation Closures

The Division in Fiscal Year 2010 closed investigations of four facilities where, after thorough investigations, the Division determined that conditions were not unlawful. These four facilities were Marion County Jail, Florida; Augusta State Medical Prison, Georgia; Winn Correctional Center, Louisiana; and Minnesota State Veterans Home.

IX. New Freedom Initiative

The Division also is charged with the enforcement of Title II of the ADA, 42 U.S.C. § 12131 et seq., and its implementing regulations 28 C.F.R. § 35.130(d), to ensure that public officials operating healthcare facilities are taking adequate steps to provide services to residents in the most integrated setting appropriate to their needs. On June 22, 2009 - the tenth anniversary of the Olmstead decision - President Barack Obama announced new initiatives to assist Americans

with disabilities and launched the "Year of Community Living" to identify improved access to housing, community supports, and independent living arrangements for persons with disabilities.[2]

During the Fiscal Year, as part of the mandate to fully enforce Title II of the ADA, the Division investigated, made findings or enforced agreements to secure increased access to residential, day, and vocational services where appropriate in the following 46 facilities:

- William F. Green State Veterans' Home, Alabama;
- Laguna Honda Hospital and Rehabilitation Center, California;
- Lanterman Developmental Center, California;
- Metropolitan State Hospital, California;
- Napa State Hospital, California;
- Patton State Hospital, California;
- Connecticut Valley Hospital, Connecticut;
- Delaware State Psychiatric Center, Delaware;
- St. Elizabeths Hospital, District of Columbia;
- Georgia mental health facilities:

  Georgia Regional Hospital – Atlanta;
  Georgia Regional Hospital – Savannah;
  Northwest Georgia Regional Hospital;
  Central State Hospital;
  Southwest State Hospital;
  West Central Georgia Regional Hospital;
  East Central Georgia Regional Hospital; and

- Clyde L. Choate Developmental Center, Illinois;

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[2] "President Obama Commemorates Anniversary of Olmstead and Announces New Initiatives to Assist Americans with Disabilities", June 22, 2009, available at http://www.whitehouse.gov/the_press_office/President-Obama-Commemorates-Anniversary-of-Olmstead-and-Announces-New-Initiatives-to-Assist-Americans-with-Disabilities/.

- Howe Developmental Center, Illinois;
- Glenwood and Woodward Resource Centers, Iowa;
- Oakwood Community Center, Kentucky;
- Rosewood Center, Maryland;
- Reginald P. White Nursing Facility, Mississippi;
- Bellefontaine Developmental Center, Missouri;
- Northwest Developmental Center, Missouri;
- Maple Lawn Nursing Home, Missouri;
- Beatrice State Developmental Center, Nebraska;
- Ancora Psychiatric Center, New Jersey;
- Ft. Bayard Medical Center, New Mexico;
- Kings County Hospital Center, New York;
- Oregon State Hospital, Oregon;
- Tucker Nursing Home, South Carolina;
- Tennessee State Veterans' Homes;
- Texas facilities for persons with developmental disabilities:

  Abilene State School;
  Austin State School;
  Brenham State School;
  Corpus Christi State School;
  Denton State School;
  El Paso State Center;
  Lubbock State School;
  Lufkin State School;
  Mexia State School;
  Richmond State School;
  Rio Grande State Center;
  San Angelo State School;
  San Antonio State School; and

- Central Virginia Training Center, Virginia.

In the Fiscal Year, the Division monitored community placements or the community systems for persons with developmental disabilities in a number of states, including Iowa and Tennessee, and the District of Columbia (in a pre-CRIPA lawsuit) and the Commonwealth of Puerto Rico.

X. Technical Assistance

Where federal financial, technical, or other assistance is available to help jurisdictions correct deficiencies, the Division advises responsible public officials of the availability of such aid, and arranges for assistance where appropriate. The Division also provides technical assistance through the information provided to jurisdictions by the Division's expert consultants at no cost to state or local government. After the expert consultants complete on-site visits and program reviews of the subject facility, they prepare detailed reports of their findings and recommendations that provide important information to the facilities on deficient areas and possible remedies to address such deficiencies. The Division routinely provides such reports to cooperative jurisdictions. In addition, during the course (and at the conclusion of) investigatory tours, the Division's expert consultants meet with officials from the subject jurisdiction and provide helpful information to jurisdictions regarding specific aspects of their programs. These oral reports permit early intervention by local jurisdictions to remedy highlighted issues before a findings letter is issued.

In addition, to ensure timely and efficient compliance with settlement agreements, the Division issued numerous post-tour compliance assessments letters (and in some cases,

emergency letters identifying emergent conditions) to apprise jurisdictions of their compliance status. These letters routinely contain technical assistance and best practices recommendations.

XI. Responsiveness to Allegations of Illegal Conditions

During Fiscal Year 2010, the Division reviewed allegations of unlawful conditions of confinement in public facilities from a number of sources, including individuals who live in the facilities, relatives of persons living in facilities, former staff of facilities, advocates, concerned citizens, media reports, and referrals from within the Division and other federal agencies. The Division received about 6,400 CRIPA-related citizen complaint letters, twice as many as it received in 2009, and received more than 200 CRIPA-related telephone complaints during the Fiscal Year. In addition, the Division responded to 387 CRIPA-related inquiries from Congress and the White House.

The Division prioritized these allegations by focusing on facilities where allegations revealed systemic, serious deficiencies. In particular, with regard to facilities for persons with mental illness or developmental disabilities and nursing homes, the Division focused on allegations of abuse and neglect, adequacy of medical and mental health care, and use of restraints and seclusion. Consistent with the requirements of Title II of the ADA and its implementing regulations, 42 U.S. C. §§ 12132 et seq.; 28 C.F.R. § 35.130(d), the Division also ensured that facilities provided services to institutionalized persons in the most integrated setting appropriate to meet their needs. Similarly, with regard to its work in juvenile justice facilities, the Division focused on allegations of abuse, adequacy of mental health and medical care, and provision of adequate rehabilitation and education—including special education services. Finally, in relation to jails and prisons, the Division placed emphasis on allegations of physical abuse (including sexual abuse and excessive use of force), adequacy of medical care and psychiatric services, and

grossly unsanitary and other unsafe conditions.

XII. CRIPA Subpoena Authority

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119. Part of this law grants the Department, for the first time, subpoena authority under CRIPA. Specifically, Section 10606(d)(2) of the Act amends CRIPA by inserting after CRIPA Section 3 ("Initiation of Actions," 42 U.S.C. § 1997a), a new CRIPA Section 3A entitled "Subpoena Authority," 42 U.S.C. § 1997a-1. The new law sets forth the specific CRIPA subpoena authority, parameters with regard to issuance and enforcement of CRIPA subpoenas, as well as direction on the protection of subpoenaed records.

XIII. Conclusion

In Fiscal Year 2011 and beyond, the Division intends to continue aggressive investigation and enforcement under CRIPA, ensuring that settlements resulting from its enforcement efforts are strong enough to adequately address unlawful deficiencies. The Division will also continue to work with jurisdictions to craft agreements that focus on bringing them into compliance, and unlike the practice used frequently in the past, the Division does not enter into agreements that terminate on a pre-set date but ensures that the jurisdiction has engaged in necessary reforms.

November 1, 2010

MEMORANDUM FOR JOAN V. YOST
INVESTIGATOR, SPECIAL LITIGATION SECTION
CIVIL RIGHTS DIVISION

FROM: Brian J. Patton, Acting Assistant Director
Program Review Division

SUBJECT: Response for the Attorney General's Report to Congress for FY 2010 Pursuant to the Civil Rights of Institutionalized Persons Act of 1997

The Bureau of Prisons appreciates the opportunity to report our actions during FY 2010 as related to the Attorney General's Report to Congress for FY 2010 pursuant to the Civil Rights of Institutionalized Persons Act of 1997.

The following is provided for insertion into the report:

FEDERAL BUREAU OF PRISONS

The Federal Bureau of Prisons (Bureau) adheres to the correctional standards developed by the American Correctional Association (ACA). These standards cover all facets of correctional management and operation, including the basic requirements related to life/safety and constitutional minima, which includes provisions for an adequate inmate grievance procedure.

Appendix A

DEPARTMENT OF VETERANS AFFAIRS
Office of the General Counsel
Washington DC 20420

JAN 14 2011

In Reply Refer To:

Tammie M. Gregg, Esq
Deputy Chief, Special Litigation Section Civil Rights Branch
U. S. Department of Justice
601 D Street N.W.
Washington, D.C. 20004

RE: Information for Inclusion in the Attorney General Report to Congress on the Civil Rights of Institutional Persons Act (42 USC 1997f)

Dear Ms. Cutlar:

Thank you for the opportunity to submit a contribution to the Attorney General's Report to Congress pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). The Department of Veterans Affairs believes we meet all existing promulgated standards for CRIPA and, in so doing, ensure the constitutionally guaranteed rights of our patients and residents. With that in mind, we are pleased to offer the enclosed information for inclusion in your report.

Sincerely yours,

Thompson

Will A. Gunn
for General Counsel

Enclosure

DEPARTMENT OF VETERANS AFFAIRS

The Department of Veterans Affairs (VA) has multiple ongoing programs to protect the civil rights of patients in its facilities. VA regulations published at 38 C.F.R. 17.33 identify the rights of patients. All patients are advised of these rights on their admission to a facility. The statement of patients' rights is required to be posted at each nursing station, and all VA staff working with patients receive training regarding these rights. Id. at 17.33(h).

The applicable regulations set forth that the specified patients' rights "are in addition to and not in derogation of any statutory, constitutional or other legal rights." Id. at 17.33(i). The regulations set forth specific procedures for VA to follow when restricting any rights, Id. at 17.33 (c), and establish grievance procedures for patients to follow for any perceived infringements of rights. Id. at 17.33(g). In addition to the regulations, the Veterans Health Administration (VHA) has issued a directive prohibiting discrimination based on race, color, national origin, limited English proficiency, age, sex, handicap, or as reprisal. VHA Directive 2008-024 (April 29, 2008).

VA further protects patients' civil rights through its program of hiring individuals to serve as Patient Advocates. The purpose of VA's Patient Advocacy Program is "to ensure that all veterans and their families, who are served in VHA facilities and clinics, have their complaints addressed in a convenient and timely manner." VHA Handbook 1003.4, Paragraph 8 (September 2, 2005). The Advocates assist patients in understanding their rights and represent them in the enforcement o f those rights. VA also facilitates the representation of patients by external stakeholders, including, but not limited to, veterans service organizations and state protection and advocacy systems, which seek to represent patients in VA facilities.

In addition, patients are also protected by VA regulations requiring the full informed consent of patients or, where applicable, their surrogates, before any proposed diagnostic or therapeutic procedure or course of treatment is undertaken. 38 C.F.R. 17.32 (c).

VA believes the receipt of high-quality medical care is the right of all patients, and takes action to achieve its provision through a number of internal mechanisms. VA operates ongoing active peer review programs designed to discover and correct problems in the provision of care. Additionally, pursuant to Presidential Executive Order 12862 (1993) which requires patient surveys and use of the resultant feedback to manage agency operations, patients are periodically surveyed to determine their satisfaction with the health care provided to them. Also, the VA Office of the Inspector General and the VA office of the Medical Inspector conduct investigations of complaints concerning the quality of health care. All of these mechanisms serve to protect the civil rights of patients in facilities operated by VA.

(It is noted that VA participates in two grant-in-aid- Programs with the States, to provide construction and renovation funds and to provide per diem payments for care of eligible veterans in State homes; however, such homes are not Federal facilities).